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NATIONAL HEALTH INSURANCE PROPOSALS

Provisions of Bills Introduced in the 93rd Congress as of July 1974

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Compiled by

SAUL WALDMAN

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration
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FOREWORD

In recent years, the need for a national plan to help individuals and families finance the cost of medical care has received increasing attention. Faced with persistent rises in medical care costs, existing methods of financing medical care are being questioned. Costs are currently covered by a combination of private efforts through out-of-pocket and health insurance premium payments, plus a diversity of government programs at the Federal, State, and local levels. Thus proposals for some form of national health insurance represent, in large part, efforts to reorganize the methods of financing medical care costs (efforts which might, in some cases, result in larger overall outlays).

Within this context, opinions vary widely concerning the most desirable approach. Proposals include implementation through a single plan or a combination of plans, with existing programs absorbed or continued. Financing mechanisms for the proposals suggest various private sources, Federal funds, State funds, and mixtures of these. Various options are also offered in the administration of the proposals, including the private sector, Federal and State governmental agencies, or combinations of private and public organizations. Various ways of permitting voluntary participation are incorporated in some of the proposals.

This report updates two earlier versions, *National Health Insurance Proposals, Provisions of Bills Introduced in the 93rd Congress as of October 1973*, and a similar report updating the proposals to February 1974. This third volume in the series presents the provisions and features of the various bills introduced as of July 1974. Prepared by Saul Waldman of the ORS Division of Health Insurance Studies, this study offers a common analytical framework for all of the proposals now before the Congress. William J. Sobaski reviewed and made significant contributions to the report. As a summary reference it should be useful for many analytical purposes as consideration of alternative ways to finance medical care in the United States continues.

John J. Carroll
Assistant Commissioner for Research and Statistics.

July 1974.

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INTRODUCTION

This report includes all of the 22 national health insurance bills introduced in the 93rd Congress as of July 1974. For this report, a national health insurance plan is defined as one which would at least (1) establish a plan by law, or provide substantial incentives for its voluntary establishment, (2) use some type of insurance mechanism, (3) potentially affect the majority of the population, and (4) specify the type of medical services to be included.

To aid in comparisons, the plans have been grouped according to their general approach as follows:

(1) Mixed public and private plans

(2) Mainly public plans

(3) Tax credit plans

(4) Catastrophic protection plans

The classification of the proposals into these groups necessarily involves a degree of arbitrariness. Differentiating between the "mixed public and private plans" and the "mainly public plans" presented relatively few problems because the two in the latter group involve mainly government financing and administration, while all those in the former group use both the private and governmental sectors for financing or administration, or both.

On the other hand, the terminology "tax credit plans," while describing clearly the nature of the approach, refer to proposals which could well be termed "mainly private."

Finally, all the "catastrophic protection plans" do in fact provide insurance against the costs of catastrophic illness for the general population, but (except the first Long bill) also provide special basic and catastrophic medical assistance for the poor.

Table A lists the bills by name (citation) and number according to their first sponsor in the House and Senate. Announced support of bills by major national organizations is indicated. The table also compares the bills with those introduced in the 92d Congress; most of the bills are identical to or modifications of bills in the last session. (All of the bills with national organizational support are new or have been modified.)

To facilitate analysis, the provisions of all the bills (regardless of their approach) have been presented according to a uniform set of subject headings. While a uniform format is not always used, the following subjects are covered for all plans:

(1) General concept and approach

(2) Coverage of the population

(3) Benefit structure

(4) Administration

(5) Relationship to other government programs

(6) Financing

(7) Standards for providers of service

(8) Reimbursement of providers of service

(9) Delivery and resources

Many of the bills include provisions specifically designed to effect changes in the methods of delivery of health care services and/or to increase the supply of health manpower and resources. These specific provisions are included in the last category. Of course other provisions, especially the standards for providers and the reimbursement methods, would often have significant effects on health delivery and resources.

Many of the plans have established the standards for providers of service to participate in the program by reference to the standards used in the present Medicare law. A description of these Medicare standards is shown on page 225.

Summary charts describing the major features of the proposals follow. The chart for the Catastrophic Illness Insurance Act, S. 1416, has been omitted since it is identical to the catastrophic illness insurance part of S. 2513, introduced by Senators Long and Ribicoff. Similarly, no chart is shown for the Comprehensive Health Insurance Act of 1974, H.R. 13603, because its provisions are almost identical to the employee and assisted plans of H.R. 12684 and S. 2970.

TABLE A.--LISTING OF NATIONAL HEALTH INSURANCE BILLS INTROOUCED IN THE 93rd CONGRESS, BY TYPE OF PROPOSAL

Type and name of bill	House		Senate		Support by national organization	Comparison with bills introduced in the 92d Congress
	First sponsor	Bill number	First sponsor	Bill number		
Mixed public and private						
The Comprehensive Health Insurance Act of 1974..	Mills-Schneebeli...	H.R. 12684.....	Packwood.....	S. 2970.....	Administration.....	New.
The National Health Care Services Reorganization and Financing Act.....	Ullman.....	H.R. 1.....	None.....	None.....	American Hospital Association.	Modified.
National Health Insurance Partnership Act of 1971.....	Railsback.....	H.R. 2618.....	None.....	None.....	.....	Identical to the previous Byrnes bill introduced on behalf of the Administration.
National Health Care Act of 1973.....	Burleson.....	H.R. 5200.....	McIntyre.....	S. 1100.....	Health Insurance Association of America.	Modified.
National Health Care Act of 1973.....	Fuqua.....	H.R. 559.....	None.....	None.....	.....	Identical to previous Burleson bill.
National Health Insurance and Health Services Improvement Act of 1973.....	None.....	None.....	Javits.....	S. 915.....	.....	Identical.
National Comprehensive Health Benefits Act of 1973.....	Staggers.....	H.R. 11345.....	None.....	None.....	.....	New.
Health Benefits and Health Services Oistribution and Education Act of 1973.....	None.....	None.....	Pell-Mondale.....	S. 2796.....	.....	Modified.
Comprehensive Health Insurance Act of 1974.....	Roy.....	H.R. 13603.....	None.....	None.....	.....	New.
National Health Standards Act.....	.....	.....	Fannin.....	S. 3353.....	Chamber of Commerce.....	New.
National Family Health Protection Act.....	Lujan.....	H.R. 15006.....	None.....	None.....	.....	Identical.
Mainly public						
The Health Security Act.....	Griffiths.....	H.R. 22.....	Kennedy.....	S. 3.....	AFL-CIO, Committee for National Health Insurance.	Modified.
National Health Insurance Act.....	Oingell.....	H.R. 33.....	None.....	None.....	.....	Identical
Comprehensive National Health Insurance Act of 1974.....	Mills.....	H.R. 13870.....	Kennedy.....	S. 3286.....	.....	New.
Tax credits						
Health Care Insurance Act of 1973.....	Fulton-Broyhill....	H.R. 2222.....	Hartke.....	S. 444.....	American Medical Association.	Modified.
Health Care Insurance Act of 1973.....	Ashbrook.....	H.R. 288.....	None.....	None.....	.....	Identical to former Fulton-Broyhill bill.
Medical Expense Tax Credit Act.....	None.....	None.....	Brock.....	S. 3670.....	.....	New.
Catastrophic protection						
National Catastrophic Illness Protection Act of 1973.....	Roe.....	H.R. 1054.....	Beall.....	S. 587.....	.....	Identical to former Hogan bill, but introduced first by Roe.
National Health Care Program.....	Saylor.....	H.R. 1916.....	None.....	None.....	.....	Identical to former Hall bill.1/
Catastrophic Health Insurance and Medical Assistance Reform Act.....	Waggonner.....	H.R. 14079.....	Long-Ribicoff.....	S. 2513.....	.....	Modification of S. 1376 and additional provisions.2/
Catastrophic Illness Insurance Act.....	Stanton.....	H.R. 8380.....	Long.....	S. 1416.....	.....	Modified.2/
The Health Rights Act of 1973.....	None.....	None.....	Scott-Percy.....	S. 2756.....	.....	Modified.

1/ Representative Hall is not a member of the 93rd Congress. 2/ S. 1416 is a modification of S. 1376 of the 92d Congress. S. 2513 includes the provisions of S. 1416 and additional provisions relating to medical assistance and certification of private health insurance.

Mixed public and private--MILLS-SCHENEEBELI--PACKWOOD BILL

Subject	Provisions		
General concept and approach----	A 3-part program including: (1) a plan requiring employers to provide private health insurance for employees, (2) an assisted plan for the low-income and high medical-risk populations, and (3) an improved Federal Medicare program for the aged. The States would supervise providers of health service and insurance carriers, under Federal guidelines. Supported by the Administration.		
	Employee plan	Assisted plan	Plan for aged
Coverage of the population------	Full-time employees, including employees of State and local governments.	Low-income families, employed or nonemployed. Also, families and employment groups who are high medical risks.	Aged persons insured under social security.
Benefit structure----------	No limits on amount of benefits listed below, except where indicated: Institutional services: Hospital inpatient and outpatient. Skilled nursing facility: 100 days per year. Personal services: Physicians. Dentists: For children under age 13. Laboratory and X-ray. Home health services: 100 visits per year. Family planning, maternity care, and well-child care (under age 6); by regulation. Other services and supplies: Prescription drugs. Medical supplies and appliances. Eyeglasses and hearing aids (and eye and ear exams): For children under age 13.		
	Deductible of $150 per person and 25 percent coinsurance, but total cost sharing limited to $1,500 annually per family ($1,050 for individuals).	Maximum cost sharing provisions are same as employee plan, but reduced according to individual or family income.	Deductible of $100 per person and 20 percent coinsurance, but total cost sharing limited to $750 per person annually. Reduced cost sharing according to individual income for low-income aged.
Administration----------	Insurance through private carriers (or self-insured arrangements) supervised by States, under Federal regulations.	Administered by States, using private carriers to administer benefits, under Federal regulations.	Administered by Federal Government in way similar to present Medicare program.
Relationship to other Government programs----------	Medicare: Program continues as the Federal plan for the aged. Medicaid: No Federal matching funds for covered benefits (or for premiums or cost sharing) under new program, but continues for specified noncovered services (such as intermediate-care facilities).		
Financing----------	Employer-employee premium payments, with employer paying 75 percent of premiums (65% for first 3 years). Temporary Federal subsidies for employers with usually high increases in payroll costs. Special provisions to assure coverage for small employers.	Premium payments from enrollees according to family income (none for lowest income groups). Balance of costs from Federal and State general revenues, with State share varied according to State per capita income.	Continuation of present Medicare payroll taxes and premium payment by aged (but no premiums for low-income aged). Federal and State general revenues used to finance reduced cost sharing and premiums for low-income aged.
Standards for providers of services----------	Similar to Medicare, with additional standards for participation of physicians' extenders.		
Reimbursement of providers of services----------	Reimbursement rates established by States, according to Federal procedures and criteria. Providers of service who elect as "full participating" would be paid the State-established rates, including the cost sharing, as full payment of their charges. Providers who elect as "associate participating" could charge more than the State rate for employee plan patients, but must collect the extra charges and cost sharing from the patients. However, all hospitals and SNF's must be full participating providers.		
Delivery and resources----------	Prepaid practice plans: Under all plans, option available to enroll in approved prepaid group or individual practice plans (which meet special standards). Regulation of insurance carriers: By State, including approval of premium rates, enforcement of disclosure requirements, annual CPA audit, and protection against insolvency of carriers. Regulation of providers: By State, including standards for participation in program, approval of proposed capital expenditures, and enforcement of disclosure requirements. Professional Standard Review Organization (PSRO): Applies to all services under program, and extends provisions to both outpatient and inpatient services.		

Mixed public and private--ULLMAN BILL

Subject	Provisions	
General concept and approach	A 3-part program covering the entire population: (1) plan requiring employers to provide private coverage for employees, (2) a plan for individuals, and (3) federally contracted coverage for the poor and aged. State establishes a health care plan, supervises carriers and insurers, and promotes a system of chartered health care corporations (HCC). Supported by AHA.	
	Private plans	Plan for low income and aged
Coverage of the population	Employees (and their families) of employers subject to the social security tax. Also, individuals who elect coverage.	Low-income and medically indigent families, and aged persons.
Benefit structure	Benefits phased in over 5-year period. Final benefits: Institutional services: Hospital: 90 days, $5 copayment per day. Skilled nursing facility: 30 days, $2.50 copayment per day. Nursing home: 90 days, $2.50 copayment per day. Personal services: Physicians: 10 visits per year, $2 copayment per visit. Laboratory and X-ray: 20 percent coinsurance. Home health services: 100 visits per year, $2 copayment per visit. Dental services: Children age 7-12: 1 exam per year, other services, 20 percent coinsurance. Other services and supplies: Prescription drugs: Limited to specified conditions, $1 per prescription. Medical equipment and appliances and ambulance service: 20 percent coinsurance. Eyeglasses: Children to age 12, 1 set per year, 20 percent coinsurance. Catastrophic coverage: Payable when certain noncovered expenses reach a specified limit, which varies by family income and age; would remove the cost sharing on all benefits and the limitation on number of hospital days and physicians' visits.	
Administration	Administered by private insurance carriers under State supervision, according to Federal guidelines.	Federal Government would contract with private insurance carriers who issue policies to eligible persons.
Relationship to other Government programs	Medicare: Abolished. Medicaid and other assistance programs: Would not pay for covered services. Other programs: Mostly not affected.	
Financing	Employee-employer premium payments, with employer paying at least 75 percent. Federal subsidy of premium for low-income workers and certain small employers, and 10 percent subsidy for HCC enrollees. Individuals pay own premium.	Financed in part by premium payments by medically indigent, but with no premium for lowest income group. Balance of cost financed by Federal general revenues and the payroll taxes of the present Medicare program.
Standards for providers of services	All institutions and HCC's must meet Medicare standards. Skilled nursing facilities must be under supervision of a hospital medical staff or have its own organized staff. Use of paramedical personnel must meet Federal standards. All providers and HCC's must establish systems of peer review, medical audit and other procedures to meet Federal-State requirements on quality and utilization of services.	
Reimbursement of providers of services	Institutions and HCC's: State commission would prospectively approve charges based on review of budget and schedule of proposed charges. Physicians and other professionals: Reasonable fee, salaries, or other compensation, as approved by State commission.	
Delivery and resources	State health commission: Establishes a State health plan, including provisions for regulation of providers and insurance carriers. Takes responsibility for health planning and must approve, in advance, proposed capital expenditures of providers. Health care corporations: State commissions would incorporate system of HCC's, approved to operate in designated geographical areas. HCC must furnish all covered services through its own faciiities or affiliated providers (and permit all qualified practitioners to furnish services for it). Would be required to hold open enrollment for public and eventually offer services on a per capita basis. Federal grants provided for HCC's for planning, development, outpatient centers, medical and data equipment, and to cover initial operating deficits.	

Mixed public and private--RAILSBACK BILL

Subject	Provisions	
General concept and approach	A 2-part national health insurance plan covering the population under age 65: (1) required employer plan providing private insurance for employees and (2) federally operated family health insurance plan (FHIP) for low-income families with children. Provisions to encourage use of health maintenance organizations.	
	Employer-employee plan	FHIP plan
Coverage of the population	Employers required to provide coverage for employees and their families. Special insurance pools for small employers, self-employed, and other individuals.	Low-income families with children who meet specified income and asset levels.
Benefit structure	All services subject to $100 annual deductible per person and 25 percent coinsurance, except as indicated. Institutional services: Hospital: 2-day deductible and 25 percent coinsurance for room and board per year. Other services subject to annual deductible and coinsurance. Personal services: Physicians: Annual deductible and coinsurance. Well-baby care: Up to age 5 without cost sharing. Laboratory and X-ray: Annual deductible and coinsurance. Other services and supplies: Medical appliances: Annual deductible and coinsurance.	No cost sharing for lowest income group; for others, according to family income. Institutional services: Hospital: 30 days of care. Extended-care facility: 3 days substituted for 1 hospital day. Personal services: Physicians: 8 visits per year (no limit in hospital). Home health services: 7 days substituted for 1 day of hospital care. Laboratory and X-ray. Family planning, maternity care, and well-baby care. Other services and supplies: Medical supplies and appliances.
Administration	Private insurance carriers. HEW determines if plan is qualified.	Administered by DHEW.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid: Limited to aged, blind, and disabled persons. Other programs: Most not affected.	
Financing	Employee-employer premium payments with employer paying 75 percent (65 percent for 1st 2-1/2 years of program). Employers with high premium costs get subsidy payments for up to 10 employees.	Financed in part by premiums paid by enrollees, graduated according to income; no premium for lowest-income group. Balance of costs paid from Federal general revenues.
Standards for providers of services	Same as Medicare.	
Reimbursement of providers of services	Hospitals and other institutions: Reasonable cost of services (same as Medicare). Physicians: Reasonable charges (same as Medicare). Health maintenance organizations: Per capita rate.	
Delivery and resources	Health maintenance organizations: Would be available as an option under all plans.	

Mixed public and private--BURLESON-McINTYRE BILL

Subject	Provisions	
General concept and approach	A 3-part voluntary health insurance plan: (1) an employee-employer plan, (2) plan for individuals, and (3) a State plan for the poor. All plans administered through private insurance carriers and provide same benefits. Supported by the Health Insurance Association of America.	
	Private plans	State plan
Coverage of the population	Employee-employer plan includes employees (and their families) of employers who voluntarily elect coverage under a qualified plan. Individual plan includes persons who voluntarily elect.	For poor and uninsurable persons.
Benefit structure	Benefits phased-in over a 10-year period for private plans and 5 years for State plan. Final benefits as follows: Institutional services: Hospital: 300 days; $5 per day. Skilled nursing facility: 180 days; $2.50 copayment per day. Personal services: Physicians: $2 copayment per visit. Dentists: 1 exam each year; other services 20 percent coinsurance. Home health services: 270 days; $2.50 copayment per day. Laboratory and X-ray: No cost sharing. Other health professionals: 20 percent coinsurance. Other services and supplies: Medical appliances: 20 percent coinsurance. Eyeglasses: No coinsurance before age 19; 50 percent after age 19. Prescription drugs: $1 copayment per prescription.	
	For employee-employer plan, annual limit for all cost sharing of $1,000 per family. For individual plans, no limit on cost sharing.	No cost sharing for lowest income families; for others, cost sharing according to family income.
Administration	Insurance administered by private carriers under State supervision. Treasury Department determines tax status of plan.	Insurance administered by private carriers under agreement with the State. Regulations for program established by DHEW.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under programs. Other programs: Most not affected.	
Financing	For employee-employer plan, premium paid by employers and employees, as arranged between them, but contributions of low-income workers limited according to their wage level. For individual plan, policyholder pay entire premium. Employees and individuals who itemize deductions can take entire premium as deduction on income tax return. Employers can take their entire premium as normal business deduction as under present law (but contributions to nonqualified plans would not be deductible).	No premium required for lowest income group; for others, premium paid by enrollees, varying according to family income. Federal and State governments pay balance of costs from their general revenues, with Federal share 70 to 90 percent, according to State.
Standards for providers of services	Same as Medicare.	
Reimbursement of providers of services	Hospitals and other institutions: Prospectively approved rates for various categories of institutions. Hospitals prepare budgets and schedule of charges which are reviewed by a State commission which approves or disapproves charges, subject to DHEW review of rate levels. Physicians and dentists: Reasonable charges, based on customary and prevailing rates.	
Delivery and resources	Health planning: Increased funding for State and local planning agencies. Planning agency approval required for projects receiving Federal assistance. Health maintenance organizations: Must be made available as an option to persons enrolled in State plan and employee-employer plans. Ambulatory health centers: Grants, loans, and loan guarantees for construction and operation of centers. Health manpower: Increases loans and grants for students, with special provisions for shortage areas.	

Mixed public and private--FUQUA BILL

Subject	Provisions	
General concept and approach	A 3-part voluntary health insurance plan: (1) an employee-employer plan, (2) plan for individuals, and (3) a State plan for the poor. All plans administered through private insurance carriers and provide same benefits.	
	Private plan	State plan
Coverage of the population	Employee-employer plan includes employees (and their families) of employers who voluntarily elect coverage under a qualified plan. Individual plan includes persons who voluntarily elect.	For poor and uninsurable persons.
Benefit structure	Benefits phased-in over a 6-year period for private plans and 4 years for State plan. Final benefits as follows: Institutional services: Hospital: 300 days; $10 copayment for 1st day, then $5 per day. Skilled nursing facility: 180 days; $2.50 copayment per day. Personal services: Physicians: $2 copayment per visit. Dentists: 1 exam each year; other services 20 percent coinsurance. Home health services: 270 days; $2.50 copayment per day. Laboratory and X-ray: No cost sharing. Other health professionals: 20 percent coinsurance. Other services and supplies: Medical appliances: 20 percent coinsurance. Eyeglasses: No cost sharing before age 19; 50 percent after age 19. Prescription drugs: $1 copayment per prescription.	
	For employee-employer plan, annual limit for all cost sharing of $1,000 per family. For individual plans, no limit on cost sharing.	No cost sharing for lowest income families; for others, cost sharing according to family income.
Administration	Insurance administered by private carriers under State supervision. Treasury Department determines tax status of plan.	Insurance administered by private carriers under agreement with the State. Regulations for program established by DHEW.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under programs. Other programs: Most not affected.	
Financing	For employee-employer plan, premium paid by employers and employees, as arranged between them. For individual plan, policyholder pays entire premium. Employees and individuals who itemize deductions can take entire premium as deduction on income tax return. Employers can take their entire premium as normal business deduction as under present law (but for nonqualified plans they would not be fully deductible).	No premium required for lowest income group; for others, premium paid by enrollees, varying according to family income. Federal and State governments pay balance of costs from their general revenues, with Federal share 70 to 90 percent, according to State.
Standards for providers of services	Same as Medicare.	
Reimbursement of providers of services	Hospitals and other institutions: Prospectively approved rates for various categories of institutions. Hospitals prepare budgets and schedule of charges which are reviewed by a State commission for approval or disapproval of charges, subject to DHEW review of rate levels. Physicians and dentists: Reasonable charges, based on customary and prevailing rates.	
Delivery and resources	Health planning: Increased funding for State and local planning agencies. Planning agency approval required for projects receiving Federal assistance. Health maintenance organizations: Must be made available as an option to persons enrolled in State plan and employee-employer plans. Ambulatory health centers: Grants, loans, and loan guarantees for construction and operation of centers. Health manpower: Increases loans and grants for students, with special provisions for shortage areas.	

Mixed public and private--JAVITS BILL

Subject	Provisions
General concept and approach----------	Program based on expansion of Medicare program to general population. Administered by Federal Government and financed by payroll taxes and Federal general revenues. Also includes option for alternative coverage under private insurance plans.
Coverage of the population----------	All U.S. residents.
Benefit structure----------	Benefits same as Medicare, plus additional benefits. Most services (except institutional) subject to present Medicare "Part B" cost sharing of $60 annual deductible per person and 20 percent coinsurance. Institutional services: Hospital: 90 days; $84 deductible, $21 copayment per day after 60th day. Skilled nursing facility: 100 days; $10.50 copayment per day after 20th day. Personal services: Physicians: Part B cost sharing. Physical checkups: 20 percent coinsurance Dentists: For children under 8; 20 percent coinsurance. Home health services: 100 visits plus 100 post-hospital visits. Laboratory and X-ray: Part B cost sharing. Other health professionals: Part B cost sharing. Other services and supplies: Medical appliances: Part B cost sharing. Prescription drugs: For chronic conditions, $1 charge per prescription.
Administration----------	Federal Government: Similar to Medicare. DHEW would have general administrative responsibility. Private insurance carriers (or quasi-governmental corporations) would handle claims and pay providers. Employer-employee plans: Employers may elect out of the Government program by establishing an approved private insurance plan providing superior benefits. Carrier plans: Individuals may elect out by purchasing approved private insurance providing equivalent benefits.
Relationship to other Government programs--	Medicare: Absorbed by program. Medicaid and other assistance programs: Would not pay for services covered under proposal. Other programs: Most not affected.
Financing----------	Tax on payroll and self-employment income plus Federal general revenues. Tax rates: (a) 3.3 percent of earnings for employers, employees, and self-employed; (b) general revenue contribution equal to 1/2 of total tax receipts. Earnings subject to tax: 1st $15,000 of earnings for employee and self-employed; total payroll for employers. Employment subject to tax: Workers under social security, plus Federal, State, and local government employees. Employer-employee plans: Employers and employees exempt from regular payroll tax. Employer pays at least 75 percent of cost of private plan.
Standards for providers of services--------	Same as Medicare. Additional standards may be established for physicians concerning continuing education, national licensing, and qualifications for major surgery and other specialists' services.
Reimbursement of providers of services-----	Same as Medicare for 1st 2 years of program; afterward, new payment methods may be established, based on a study required under bill. In interim, hospitals and nursing homes receive reasonable costs of services; physicians, dentists, and suppliers receive appropriate and reasonable charges. Comprehensive health service systems paid reasonable cost or per capita rate for enrolled members.
Delivery and resources----------	Comprehensive health service systems: DHEW can contract with comprehensive systems to provide health care to enrolled population. Systems must provide all covered services, preventive services, health education, and must train paramedical health personnel. Loans, grants, and technical assistance provided for the development, operation, and construction of comprehensive systems.

Mixed public and private--STAGGERS BILL

Subject	Provisions	
General concept and approach	A 3-part program: (1) a plan requiring employers to provide private coverage for employees, (2) a plan for individuals, and (3) federally contracted plan for the poor and aged. State establishes a health care plan, supervises carriers and insurers, and promotes a system of health maintenance organizations (HMO's).	
	Private plans	Plan for low income and aged
Coverage of the population	Employees and their families of employers subject to the social security tax. Also, other persons who elect coverage.	Low-income and medically indigent families, and aged persons.
Benefit structure	Benefits phased in over 6-year period. Final benefits: Institutional services: Hospital: 60 days, $5 copayment per day. Skilled nursing facility: 30 days, $2.50 copayment per day. Nursing home: 60 days, $2.50 copayment per day. Personal services: Physicians: 50 visits per year, $3 copayment per visit. Laboratory and X-ray: 20 percent coinsurance. Home health services: 100 visits per year, $2 copayment per visit. Dental services: Children age 7-12: 1 exam per year; other services, 20 percent coinsurance. Other services and supplies: Prescription drugs: Limited to specified conditions, $1 per prescription. Medical equipment and appliances and ambulance service: 20 percent coinsurance. Eyeglasses: Children to age 15, 1 set per year, 20 percent coinsurance. Catastrophic coverage: Payable when certain noncovered expenses reach a specified limit, which varies by family income and age; would remove the cost sharing on all benefits and the limitation on number of hospital days and physicians' visits.	
Administration	Administered by private insurance carriers under State supervision, according to Federal guidelines.	Federal Government would contract with private insurance carriers who issue policies to eligible persons.
Relationship to other Government programs	Medicaid and other assistance programs: Would not pay for covered services. Other programs: Most not affected.	
Financing	Employee-employer premium payments, with employer paying at least 75 percent. Federal subsidy of premium for low-income workers and certain small employers; and 10 percent subsidy for HMO enrollees. Individuals pay own premium.	Financed in part by premium payments by medically indigent, but with no premium for lowest income group. Balance of cost financed by Federal general revenues.
Standards for providers of services	All institutions and HMO's must meet Medicare standards. Use of paramedical personnel must meet Federal standards. All providers must meet Federal-State quality and disclosure requirements.	
Reimbursement of providers of services	Institutions and HMO's: State commission would prospectively approve charges based on review of budget and schedule of proposed charges. Physicians and other professionals: Reasonable fee, salaries, or other compensation, as approved by State commission.	
Delivery and resources	State health commission: Establishes a State health plan, including provisions for regulation of providers and insurance carriers. Takes responsibility for health planning and must approve, in advance, proposed capital expenditures of providers. HMO's: State commissions would regulate a system of approved HMO's. HMO must furnish all covered services through its own facilities or other providers (including arrangements with medical groups or individual practice associations). Would be required to hold open enrollment for public and must eventually offer services on a capitation basis. Federal grants provided for planning, development, outpatient centers, and initial operating expenses.	

Mixed public and private--PELL-MONDALE BILL

Subject	Provisions
General concept and approach----------	Employers would be required to provide specified health benefits for their employees and families, at no cost to the employee. Authorizes creation of health services corporations to furnish comprehensive health care and operate facilities.
Coverage of the population----------	Employees and their families of businesses in interstate commerce, and Federal, State, and local government agencies.
Benefit structure----------	Required benefits, with limitations, as noted. Institutional services: Hospital: 12 days a year, after 1st 2 days. Nursing home: 10 days a year. Personal services: Physicians. Laboratory and X-ray. Other health professionals: Podiatrists and chiropractors. Other services and supplies: Medical appliances. Prescription drugs. Catastrophic: Coverage of medical costs which exceed 25 percent of family income.
Administration----------	Benefits administered through prepaid health plans, health services corporations, or other approved methods. DHEW would establish standards and regulations for program.
Relationship to other Government programs--	Medicare: Continues to operate. Medicaid: Would not pay for covered services. Other programs: Most not affected.
Financing----------	Employers pay total cost, as cost of doing business. No charge to employees.
Standards for providers of services--------	DHEW would establish regulations regarding standards for facilities, quality standards, and necessity of services.
Reimbursement of providers of services-----	As arranged by employers with providers.
Delivery and resources----------	Health services corporations: For-profit organizations to be established in an area to provide comprehensive health services (including required benefits), and operate health facilities and medical schools. Would purchase health facilities and/or make arrangements with providers of services. Funded mainly by sale of stock to State and local government, and health organizations and personnel affiliated with corporation. Corporation facilities and staff must meet national standards. Federal grants, loans, and guarantees available for construction, staffing, and operation. Regional planning councils: Develop plans for comprehensive health services. Would approve the budgets of health service corporations and all projects involving Federal funds.

Mixed Public and Private--FANNIN BILL

Subject	Provisions	
General concept and approach----------	A 2-part program including (1) a plan requiring employers to offer health insurance coverage to their employees and (2) a State plan for low-income families.	
	Employer-employee plan	Low-income plan
Coverage of the population----------	Full-time employees, including employees of Federal, State, and local governments.	Low-income families.
Benefit structure----------	No limit on amount of benefits, except where indicated: Institutional services: Hospital. Skilled nursing facility: By regulation. Personal services: Physicians. Laboratory and X-ray. Other services and supplies: Prescription drugs. Medical supplies and appliances.	
	Deductible of $100 per person and 25 percent coinsurance, but total limit to $2,600 annually per family. Actuarially equivalent benefits may be substituted for specified ones.	10-percent coinsurance, but limited to 5 percent of annual family income.
Administration----------	Private health insurance carriers (or self-insured arrangements) supervised by the States, under Federal regulations.	Administered by States through private carriers.
Relationship to other Government programs--	Medicare: Continues. Medicaid: Abolished. Other programs: Most not affected.	
Financing----------	Employee-employer premium payments, with employer required to pay at least 50 percent of cost. Special pools for small employers and self-employed.	Premium payments from enrollees according to family income, with none for lowest income group. Balance of cost from Federal general revenues.
Standards for providers of services--------	Same as under Medicare.	
Reimbursement of providers of services-----	Institutions: Prospective budgets with uniform payment rates per specified period of time (e.g. per day) for all patients. Physicians: Usual and customary charges.	
Delivery and resources----------	Health maintenance organizations: Under both plans, option available to enroll in approved HMO's. Professional Standards Review Organization (PSRO): Would apply to all services under program. Regulation of providers: Proposed and existing capital facilities and services must be approved by local planning agency.	

Mixed Public and Private--LUJAN BILL

Subject	Provisions
General concept and approach----------	A plan under which the Federal Government would issue certificates to families to purchase private health insurance.
Coverage of the population----------	All U.S. residents.
Benefit structure----------	No limits on amount of benefits and no cost sharing, except where indicated: Institutional services: Hospital: } No cost sharing for 120 days; afterward, Extended care facility: } 20 percent to 50 percent of cost. Personal services: Physicians: $50 deductible, maximum of $5 per visit. Laboratory and X-ray. Home health services. Other services and supplies: Medical equipment and supplies. Maternity care: $100 deductible.
Administration----------	Families would apply for a health protection certificate on their Federal income tax return. The certificate would be accepted by carriers as full premium payment for a qualified health insurance policy.
Relationship to other Government programs--	Medicare: Abolished. Medicaid: Abolished. Other government programs: Not affected.
Financing----------	Financed by a 5-percent surcharge on Federal personal income taxes. Federal Government would redeem certificates from carriers for their actuarial value.
Standards for providers of services--------	Same as under Medicare.
Reimbursement of providers of services-----	Institutions: Same as Medicare.
Delivery and resources----------	No provisions.

Mainly public--GRIFFITHS-KENNEDY BILL

Subject	Provisions
General concept and approach	A program providing broad benefits, administered by Federal Government and financed by payroll taxes and Federal general revenues. Supported by Committee for National Health Insurance and AFL-CIO.
Coverage of the population	All U.S. residents.
Benefit structure	Benefits with no limitations, except as noted, or cost sharing. Institutional services: Hospital. Skilled nursing facility: 120 days of care. Personal services: Physicians. Dentists: For children under age 15; scheduled extension to age 25; eventually to entire population. Home health services. Other health professionals. Laboratory and X-ray. Other services and supplies: Medical appliances and ambulance services. Optometrists and eyeglasses. Prescription drugs: As needed for chronic illness and other specified diseases.
Administration	Federal Government: Special board in DHEW, with regional and local offices to operate program.
Relationship to other Government programs	Medicare: Abolished. Medicaid and other assistance programs: Would not pay for covered services. Other programs: Most not affected.
Financing	Tax on payroll, self-employed, and unearned income, and Federal general revenues. Tax rates: (a) 1.0 percent on employee wages and unearned income, (b) 3.5 percent for employers, (c) 2.5 percent for self-employed, and (d) Federal general revenues equal to total receipts from taxes. Income subject to tax: 1st $15,000 annually for individuals; total payroll for employers. Employment subject to tax: Workers under social security, plus Federal, State, and local government employment. State and local governments do not pay employer tax.
Standards for providers of services	Same as Medicare, but with additional requirements: Hospitals cannot refuse staff privileges to qualified physicians. Skilled nursing facilities must be affiliated with hospital which would take responsibility for quality of medical services in home. Physicians must meet national standards; major surgery performed only by qualified specialists. All providers: Records subject to review by regional office. Can be directed to add or reduce services, provide services in a new location, and to establish linkages with other providers.
Reimbursement of providers of services	National health budget established and funds allocated, by type of medical services, to regions and local areas. Hospitals and nursing homes: Would receive annual predetermined budget, based on reasonable cost. Physicians, dentists, and other professionals: Methods available are fee-for-service based on fee schedule, per capita payment for persons enrolled, and (by agreement) full- or part-time salary. Payments for fee-for-service may be reduced if payments exceed estimates. Health maintenance organizations and medical society foundations: Per capita payment for all services (or budget for institutional services). Can retain all or part of savings.
Delivery and resources	Health planning: DHEW responsible for health planning, in cooperation with State planning agencies. Priority to be given to development of comprehensive care on ambulatory basis. Health resources development fund: Will receive, ultimately, 5 percent of total income of program, to be used for improving delivery of health care and increasing health resources. Health maintenance organizations: Grants for development, loans for construction, and payments to offset operating deficits. Manpower training: Grants to schools and allowances to students for training of physicians for general practice and shortage specialties, other health occupations, and development of new kinds of health personnel.

Mainly public--DINGELL BILL

Subject	Provisions
General concept and approach----------	Program providing health benefits, administered at Federal, State, and local levels and financed by payroll taxes.
Coverage of the population----------	All U.S. residents.
Benefit structure----------	Benefits with no cost sharing or limitations, except as noted. Institutional services: Hospital: 60 days of care. Personal services: Physicians. Dentists. Home health services. Laboratory and X-ray. Other health professionals. Other services and supplies: Medical appliances and eyeglasses. Prescription drugs: Unusually expensive drugs. Specified benefits may be delayed in a State if resources are inadequate.
Administration----------	Federal Government: Special board in DHEW with overall supervision of program. State: Under contract with Federal Government, would establish State plan to operate program at the local level.
Relationship to other Government programs--	Medicare: Continues to operate, but study to be made of methods of incorporating it into the national plan. Medicaid and other assistance programs: Would not pay for services under the national plan. Other programs: Most not affected.
Financing----------	Tax on wage and self-employment income similar to social security tax. Total tax for employers and employees combined would be 4 percent.
Standards for providers of services--------	Must meet State standards. If no State standards, they would be established by national board.
Reimbursement of providers of services-----	Hospitals and other institutions: Reasonable cost of services, but subject to a maximum rate. Physicians and other professionals: Fee for service (based on fee schedule), per capita (for persons enrolled with a practitioner), or salary.
Delivery and resources----------	Grants to students and educational institutions for training in health occupations.

Mainly public--MILLS-KENNEDY BILL

Subject	Provisions		
General concept and approach----	A 2-part program including: (1) a national health insurance plan for the general population and (2) a revised Medicare program for the aged and disabled, including a new long-term care benefit plan. Both programs administered by an independent SSA. Includes provisions for improving health resources and delivery.		
	National health insurance	Medicare, regular	Medicare, long-term benefits
Coverage of the population------	Persons insured or eligible under social security, working full time, or under the AFDC or SSI program.	Same as present Medicare program (aged and disabled).	
Benefit structure----------	No limits on benefits, except where indicated: Institutional services: Hospital inpatient and outpatient. Skilled nursing facility: 100 days per year. Personal services: Physicians. Dentists: For children under age 13. Laboratory and X-ray. Home health services: 100 visits per year. Family planning, maternity care, and well-child care (under age 6): by regulation. Other services and supplies: Prescription drugs: For specified chronic illnesses. Medical supplies and appliances. Eyeglasses and hearing aids (and eye and ear exams): For children under age 13.		Home health services. Homemaker services. Meals-on-wheels. Outpatient mental health services. Day care. Foster home care. Skilled nursing facility. Intermediate care facility.
	Deductible of $150 per person and 25% coinsurance, with total cost sharing limited to $1,000 per family, but eliminated or reduced for low-income families.	Cost sharing same as present Medicare program, but eliminated or reduced for low-income families.	No cost sharing required, except the amount of any social security or SSI cash benefits payable would be reduced for persons receiving institutional services.
Administration----------	Administered by independent SSA (no longer part of DHEW) in manner similar to present Medicare program, using insurance carriers to process claims (but with new standards for carriers).		New community centers provide or arrange for services; supervised by State agency, with SSA having final authority.
Relationship to other Government programs----------	Medicare: Revised program continues, as indicated. Medicaid: Abolished. Other programs: Most not affected.		
Financing----------	National health insurance: Special tax on payroll (3% for employers and 1% for employees), self-employment income (2-1/2%), unearned income (2-1/2%), and AFDC and SSI payments (3% for government and 1% for recipients). Income subject to tax: First $20,000 annually for combined taxable income of husband and wife, or for individual, and for employer tax on one employee. Employment subject to tax: Workers under social security and Federal, State, and local employees. Medicare: Continuation of same financing provisions.		Enrollees pay premium of $6 monthly. Balance from Federal and State general revenues, 90% and 10%, respectively.
Standards for providers of services----------	Standards similar to Medicare, with additional standards for physicians' assistants. Major surgery and other specialized service covered only when performed by qualified specialist.		Standards for community long-term centers established by State agency.
Reimbursement of providers of services----------	Institutions: Reimbursed according to prospective reimbursement methods to be developed by SSA. Paid as "participating" providers (see below). Practitioners: Fee scheduled proposed by medical society or equivalent organization and approved by SSA. Practitioners who elect to "participate" would receive scheduled amount including the cost sharing due from patient. Nonparticipating practitioners could charge more than schedule, but would need to collect the cost sharing and extra charges from the patient.		Community centers reimbursed by State agency according to prospective reimbursement method approved by SSA.
Delivery and resources----------	Regulation of providers: Services, facilities, and capital expenditures of institutions must be approved by State and local planning agencies. Professional Standards Review Organization (PSRO): Applies to all inpatient and outpatient services under program. Private insurance: DHEW would officially certify supplemental private health insurance policies meeting specified requirements. Health resource development board: Receives 1% of NHI program funds to improve health resources and delivery. Makes grants and loans for development and construction of HMO's, primary care centers, and certain other organizations, and for specified manpower training. Promotes area and State health planning.		

Tax credits--FULTON-BROYHILL--HARTKE BILL

Subject	Provisions
General concept and approach----------	Would provide credits against personal income taxes to offset the premium cost of qualified private health insurance providing specified benefits. Also, would require employers to provide qualified policies to retain favorable tax treatment. Supported by American Medical Association.
Coverage of the population----------	All U.S. residents, on voluntary basis.
Benefit structure----------	Tax credits of 10 to 100 percent of cost of qualified health insurance policy, depending on annual tax payments. Voucher certificates issued to persons with little or no tax liability. Institutional services: Hospital: 60 days of care; $50 deductible per stay. Skilled nursing facility: Substituted for hospital days on 2 for 1 basis; $50 deductible per stay. Personal services: Physicians: 20 percent coinsurance. Dental care: Initially for children age 2-6. Later extended up to age 17. Home health services: 20 percent coinsurance. Laboratory and X-ray: 20 percent coinsurance. Other services and supplies: Ambulance services: 20 percent coinsurance. Catastrophic coverage: Unlimited hospital days, an additional 30 days in a skilled nursing facility, prosthetic devices, and blood (after 3 pints) covered after corridor deductible (out-of-pocket payment) which varies according to income. Total coinsurance for physicians, laboratory and X-ray combined limited to $100 per family; separate limit of $100 for hospital outpatient, home health, and ambulance; and separate limit of $100 for dental care. Medicaid program would pay all cost sharing for cash assistance recipients.
Administration----------	Private insurance carriers issue health insurance policies. State insurance departments certify carriers and qualified policies. DHEW issues voucher certificates. A new Federal board establishes standards for program.
Relationship to other Government programs--	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under program. Other programs: Most not affected.
Financing----------	Tax credits financed from Federal general revenues. Employers must provide qualified policies as a condition of taking the full premium cost as a normal business deduction.
Standards for providers of services--------	No provisions.
Reimbursement of providers of services-----	Usual and customary charges.
Delivery and resources----------	No provisions.

Tax credits--ASHBROOK BILL

Subject	Provisions
General concept and approach	Would provide credits against personal income taxes to offset the premium cost of qualified private health insurance prôviding specified benefits. Also would require employers to provide qualified policies to retain favorable tax treatment.
Coverage of the population	All U.S. residents, on voluntary basis.
Benefit structure	Tax credits of 10 to 100 percent of cost of qualified health insurance policy, depending on annual tax payments. Voucher certificates issued to persons with little or no tax liability. Institutional services: Hospital: 60 days of care; $50 deductible per stay. Extended-care facility: Substituted for hospital days on 2 for 1 basis; $50 deductible per stay. Personal services: Physicians: 20 percent coinsurance. Laboratory and X-ray: 20 percent coinsurance. Catastrophic coverage: Additional hospital days, 30 nursing facility days, and prosthetic devices covered after corridor deductible (out-of-pocket payment) which varies according to income. Total coinsurance (for physicians, laboratory and X-ray) limited to $100 per family. Additional limit of $100 for hospital outpatient services.
Administration	Private insurance carriers issue policies. State insurance departments certify carriers and qualified policies. DHEW issues voucher certificates. The new Federal board establishes standards for program.
Relationship to other Government programs	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services under program. Other programs: Most not affected.
Financing	Tax credits financed from Federal general revenues. Employers must provide qualified policies as a condition of taking the full premium cost as a normal business deduction.
Standards for providers of services	No provisions.
Reimbursement of providers of services	Usual and customary charges.
Delivery and resources	No provisions.

Tax Credit--BROCK BILL

Subject	Provisions
General concept and approach----------	The proposal would provide tax credits against personal income taxes when medical expenses exceeded a specified percent of family income.
Coverage of the population----------	All U.S. residents, on voluntary basis.
Benefit structure----------	The credit against income taxes would be payable if medical expenses exceeded 15 percent of modified adjusted gross income. The credit would be equal to 85 percent of the excess amount. Adjusted gross income would be modified by subtracting the amount of personal exemptions ($750 for each exemption) and adding certain excluded capital gains and interest income. The definition of medical expenses would be similar to that used for the present medical expense income tax deduction.
Administration----------	Persons would be required to file an income tax return. The full amount of the tax credit would always be payable without regard to the amount (if any) of taxes.
Relationship to other Government programs---	The President would study the possibilities of ending, reducing, or changing the Medicare, Medicaid, and other Federal programs.
Financing----------	The proposal would be financed from Federal general revenues. The present medical expense deduction would be repealed.
Standards for providers of services---------	No provisions.
Reimbursement of providers of services------	No provisions.
Delivery and resources----------	No provisions.

Subject	Provisions
General concept and approach----------	Program which would pay medical expenses when they exceed a specified amount. Administered by private insurance companies under State supervision and financed by private premium payments and Federal subsidy.
Coverage of the population----------	All U.S. residents, on voluntary basis.
Benefit structure----------	All services eligible as medical expense deductions under the income tax law may be covered after family medical expenses exceed a specified amount (the deductible) which varies according to family income and size. There is no deductible for low-income families but the deductible rises rapidly as income increases. Expenses paid by other private insurance or government programs can be counted toward the deductible.
Administration----------	Private insurance carriers would issue and administer the insurance policies. Each State would design and establish a plan. DHEW would establish regulations for the program.
Relationship to other Government programs--	Medicare: Continues to operate. Medicaid and other assistance programs: Would not pay for services covered under the program. Other programs: Most not affected.
Financing----------	Policyholders would pay premium. Premium rate: DHEW would determine actuarial value of policies, but could set a premium rate lower than the actuarial value to encourage widespread enrollment. It would pay carriers (from general revenues) the difference between the actuarial value and the premium rate. Reinsurance: DHEW would arrange a reinsurance mechanism. The carrier would pay the reinsurance premiums.
Standards for providers of services--------	No provisions.
Reimbursement of providers of services-----	No provisions.
Delivery and resources----------	No provisions.

Catastrophic protection--SAYLOR BILL

Subject	Provisions	
General concept and approach	A 2-part program: (1) State plan of health insurance for the poor providing basic and catastrophic coverage and (2) Federal program of catastrophic protection for the rest of the population.	
	Poor	General population
Coverage of the population	All medically indigent persons.	All persons not medically indigent.
Benefit structure	All services eligible as medical expense deductions under the income tax law may be covered.	
	Insurance providing basic coverage of medical care and catastrophic protection of additional costs. Types of services determined by State. No cost sharing.	Coverage of 90 percent of family health care costs after the 1st $5,000 of expenses ($1,000 for the aged). Expenses paid by private insurance or public programs can be counted toward this deductible amount.
Administration	Private insurance companies would issue insurance policies and administer claims. DHEW would establish plan if State does not.	Administered by DHEW, using same procedures and requirements as Medicare, if possible.
Relationship to other Government programs	Would replace Medicaid program.	No specific reference. DHEW to report on laws that need to be changed.
Financing	Federal and State government general revenues. Federal pays 85 percent of cost of basic coverage. State pays remaining costs and cost of catastrophic protection.	Special tax on wages, self-employment income, and other income of individuals. Tax rate: 0.4 percent. Earnings subject to tax: Sum of an individual's wages, self-employment income, and other earned or unearned income over $2,000, up to a maximum of $7,800. Employment subject to tax: Same as social security.
Standards for providers of services	No provisions.	Same as Medicare, as much as feasible.
Reimbursement of providers of services	No provisions.	Same as Medicare, as much as feasible.
Delivery and resources	No provisions.	No provisions.

Catastrophic protection--LONG-RIBICOFF--WAGGONNER BILL

Subject	Provisions	
General concept and approach	Includes a (1) catastrophic illness plan for the general population and (2) Federal medical assistance plan for the poor and medically indigent. Both plans administered through the Medicare program. Also includes provisions designed to encourage improvement of private health insurance and establishment of insurance pools.	
	Catastrophic plan	Medical assistance plan
Coverage of the population	Persons of all ages insured, or receiving benefits, under social security.	Families with income below specified amounts, varying by family size, regardless of age or employment status. Also families above specified limits under a "spend-down" provision which takes account of both family income and medical expenses. Present Medicaid eligibles automatically covered.
Benefit structure	Same types of benefits as Medicare, but payable only when expenses reach specified catastrophic proportions: Institutional services: Hospital inpatient: Coverage begins after first 60 days in hospital, unlimited additional days covered; $21 per day copayment. Skilled nursing facility: 100 days, available only to persons who received catastrophic hospital benefits; $10.50 per day copayment. Personal services:1/ Physicians services. Laboratory and X-ray. Home health services. Other services:1/ Medical supplies and appliances. Ambulance services. Total coinsurance limited to $1,000 annually per person.	No limits on amount of services and no cost sharing, except as indicated: Institutional services: Hospital inpatient: 60 days. Skilled nursing facility. Intermediate care facility. Personal services: Physicians services: $3 copayment for 1st 10 visits per family. Laboratory and X-ray. Home health service. Other services and supplies: Medical supplies and appliances. Ambulance services. Program would also pay full cost of benefits under catastrophic plan for medical assistance recipients not covered by the catastrophic plan, and necessary cost sharing for those who are covered. Would pay SMI premium for its aged eligibles.
Administration	Administered through the Medicare program, under which private carriers handle claims and pay providers of service.	
Relationship to other Government programs	Medicare: Continues to operate. Medicaid: Would pay last. Other programs: Mostly not affected.	Medicare: Continues to operate. Medicaid: Program abolished. Other programs: Mostly not affected.
Financing	As under Medicare, special tax on the wages and self-employment income subject to the social security tax. Tax rate: Initially, 0.3 percent, rising ultimately to 0.4 percent.	Financed by State and Federal general revenues. State share: Amount equal to present State share of Medicaid payment for types of service under new program, with additions or subtractions depending on liberality of present Medicaid program. Federal share: Balance of cost.
Standards for providers of services	Same as Medicare. Also, intermediate care facilities must be licensed by State and meet additional requirements.	
Reimbursement of providers of services	Same as Medicare (including the reimbursement provision of P.L. 92-603). For medical assistance program, physicians and other providers must accept plan's payment as payment in full.	
Delivery and resources	Incorporates the provisions of P.L. 92-603, including HMO provisions, and Professional Standards Review Organization (PSRO).	
Encouragement of improved insurance	Private carriers could voluntarily submit health insurance policies for certification by DHEW. Emblem of certification could be used in advertising and only "approved" carriers offering these policies could act as Medicare intermediaries. Certified policy must (1) include specified benefits (60 hospital days and $2,000 medical coverage) with limitations on cost sharing, (2) could not exclude preexisting conditions, and (3) if an employment group policy, continue coverage for terminated employees. Also, bill suspends certain antitrust laws, thus permitting insurance "pool" arrangements to offer certified insurance.	

1/ Payable after family has incurred $2,000 in medical expenses in year; 20 percent coinsurance.

Catastrophic protection--SCOTT-PERCY BILL

Subject	Provisions	
General concept and approach	An insurance program for the general population including (1) a plan providing catastrophic protection against the cost of inpatient hospital and related services and (2) a plan providing supplementary medical insurance. Includes provisions for review of the utilization of services, development of health maintenance organizations, and improvements in the delivery of health services.	
	Inpatient health care	Supplementary medical care
Coverage of the population	All residents who have enrolled in the supplementary medical plan.	All residents, on voluntary basis.
Benefit structure	Benefits subject to a family deductible varying in amount according to family income and size and, in some cases, the amount of the institutions' charges. Following benefits covered, without limit on days or amount of services: Hospital. Skilled nursing facility. Home health services.	Benefits subject to a common deductible of $10 to $50 per person, according to family income and size (but with a separate deductible of $10 to $25 for dental care). No limits on services except as indicated: Personal services: Physicians. Dentists: For children under 12. Home health services. Laboratory and X-ray. Other health professionals. Physical checkups: For children under age 5. Other services and supplies: Prescription drugs: Drugs required for chronic illnesses. Medical supplies and equipment. Ambulance services.
Administration	Administered by DHEW, through contracts with insurance carriers or other private or public administrative intermediaries (or special contracts with approved HMO's).	
Relationship to other Government programs	Medicare: Abolished. Medicaid and other assistance programs: Would not pay for covered services. Other programs: Most not affected.	
Financing	Financed by (1) present Medicare payroll taxes which would be diverted to the new program and (2) Federal general revenues, to extent needed.	Financed by premiums paid by enrollees. Federal subsidy from general revenues of premiums for low-income families, varying according to family income and size (but with no premiums for the lowest income group).
Standards for providers of services	Institutions must meet standards of present Medicare program. Also, providers' staffing patterns and qualifications of personnel must meet Federal standards to be established by regulation. Professional and allied health personnel who meet Federal standards would be qualified to practice in any State.	
Reimbursement of providers of services	Reasonable cost of services, as under present Medicare program.	
Delivery and resources	Health maintenance organizations: Grants and loans for development and construction of HMO's. Special provisions for enrollment and capitation payments for HMO's under the new insurance program. Utilization review: Incorporates and expands provisions of Professional Review Standards Organizations (PSRO). National Professional Review Council: (1) Reviews activities of PSRO's, (2) advises Department on overall administration of program, (3) develops standards for training of health personnel. Health Delivery Committee: Studies current and future needs for health personnel.	

MILLS-SCHNEEBELI--PACKWOOD BILL

"The Comprehensive Health Insurance Act of 1974" was introduced by Representatives Wilbur D. Mills of Arkansas and Herman T. Schneebeli of Pennsylvania as H.R. 12684, and by Senator Bob Packwood of Oregon as S. 2970. It is endorsed by the Administration.

General Concept and Approach

The proposal would establish a three-part national program including (1) an employee health care benefits program requiring employers to offer specified private health insurance to their employees, (2) a State-operated assisted health care program providing coverage for low-income families and for families and employment groups who are high medical risks for health insurance, and (3) a Federal health care program for aged persons, representing in effect an expanded Medicare program. All programs would offer the same scope of health services and provide protection against the costs of catastrophic illness.

The State governments would have major responsibility for the supervision of the employee program, administration of its assisted health insurance program, and the regulation of insurance carriers and providers of health services--all in accordance with Federal guidelines or rules.

The program includes provisions to facilitate enrollment in prepaid practice plans by providing an option for persons under all plans of the proposal to enroll in prepaid plans. Also, a new system of reimbursement of providers of health services would be established under the program.

EMPLOYEE HEALTH CARE INSURANCE PLAN

The employee plan would require employers to make available to their full-time employees a health care benefits plan providing a broad range of hospital, medical, and preventive services and protection against catastrophic illness. Coverage would be implemented through private health insurance and financed through employer and employee premium contributions, with temporary Federal subsidies for firms with unusually high increases in premium costs.

Coverage

Employers with one or more eligible full-time employees--measured by a test of number of weeks and hours of work--would be required to offer coverage and contribute toward the premium for a health care plan covering the employee and his family. To qualify as an eligible full-time employee, the employee must work for (a) at least 25 hours per week for at least 10 weeks or (b) a total of 350 hours, in the preceding 13-week period. Thus, for a new 40-hour-week worker, coverage with full employer contributions would start during the ninth week of employment (that is, after 350 hours of work).

However, if an employer is already providing coverage under these regular provisions, any employee working 25 hours a week could elect coverage (starting in the following week) by paying the full premium himself at the group premium rate.

The law would apply to all employers (as employer is defined by the common law) and would include State and local governments, but not the Federal Government or agencies of foreign governments or international organizations. Employees age 65 and over and aged members of an employee's family would not be eligible under the employee plan. For eligible employees, participation in the plan would be voluntary.

Continuation of Coverage

Coverage under an employee benefit plan, with full employer contributions, would continue for at least 90 days after termination of work. It could continue an additional 90 days, at the option of the employee, with the employee paying the entire premium at the group premium rate. These 180 days of additional coverage would provide protection during periods of unemployment, the beginning period of a new job, and periods of disability.

Benefit Structure

The required benefits under an employee health care plan include hospital, skilled nursing facilities, physicians, home health, and diagnostic services, and such additional benefits as prescription drugs, preventive care, and special services for children.

A plan could not exclude benefits for preexisting medical conditions, require any waiting period before benefits become payable, or impose any maximum limit on the total amount of benefits payable on an annual, lifetime, or any other basis. The required basic benefits are shown in table 1.

TABLE 1.--Covered services under the proposal

Type of service	Limit on benefits	Other information
Institutional services		
Hospital inpatient	No limit	Special limitations for mental illness.
Skilled nursing facilities	100 days per year	Available after a hospital stay of 3 days or more.
Personal services		
Physicians' services	No limit	Includes home, office, and hospital visits. Special limitations for mental illness.
Home health services	100 visits per year	----------
Laboratory and X-ray	No limit	----------
Outpatient physical therapy services	No limit	----------
Podiatrist services	No limit	Excludes routine foot care.
Preventive services:		
Family planning services	By regulation	Includes services and supplies.
Prenatal and maternity care	By regulation	----------
Well-child care	By regulation	For children under age 6.
Special services for children:		
Dental services (for children under age 13)	No limit	Routine services including examinations, fillings, extractions and replacements; excludes orthodontia.
Vision services (for children under age 13)	By regulation	Includes eye examinations and eyeglasses.
Hearing services (for children under age 13)	By regulation	Includes examinations and hearing aids.
Other services and supplies		
Prescription drugs	No limit	Includes full range of drugs of kinds available only by prescription, and any additional lifesaving drugs provided by regulation.
Blood and blood products	By regulation	----------
Prosthetic devices	No limit	----------
Medical equipment and supplies	No limit	----------
Ambulance services	By regulation	Only when medically necessary.

Mental Illness

Under special limitations applying to mental illness, inpatient hospital care for mental illness is limited to 30 days in a year. Partial hospitalization (such as day or night care) is specifically covered, with 2 days of partial care substituted for each of the 30 available days of hospital care.

The total amount of benefit payments for outpatient mental illness services would be initially calculated by estimating the total charges for 30 visits to a private practitioner for the treatment of mental illness. (For illustration, 30 visits at say $30 a visit, or $900.)

However, the amount determined by this calculation represents the maximum amount of benefits payable annually for care in an approved comprehensive community care center. For care by a private practitioner or in other settings, the benefits payable would be one-half that maximum amount. (In the illustration above, $450.)

In either case, no limit is set on the actual number of visits in any setting (the reference in the law to 30 visits is given only to provide a basis for calculating the maximum dollar amount of benefits that would be payable).

Cost Sharing

Payment for all covered services, except drugs, would be subject to a common deductible of $150 annually per person (but with no further deductible after three members of a family have met the deductible for the year). Payment for drugs would be subject to a separate deductible of $50 annually per person (without regard to the regular $150 deductible). A separate deductible may be imposed on blood and blood products, by regulation. (There is no separate deductible for inpatient hospital care.)

Payment for all covered services, above the deductibles, would be subject to a coinsurance rate of 25 percent.

The maximum amount of cost sharing (deductibles and coinsurance) would be limited to $1,050 in a year for an individual and $1,500 for a family. Above that amount (referred to as the maximum family liability) all covered services would be provided with no further payment that year by the patient.

These deductibles would be in effect during the first 2 years of the program. Each year thereafter, the amount of the regular deductible would be raised in proportion to the increase in the average cost of the required benefit package. The drug deductible would also be increased so that it would continue to be one-third of the regular deductible.

Cost sharing paid during the year under the three plans of the proposal would be combined and counted toward the annual deductibles and the maximum family liability for cost sharing.

With unlimited hospital and other expensive services covered (including kidney dialysis and transplants) and with a limit on total cost sharing, the employee plan would protect most covered families against the high costs of catastrophic illnesses.

Additional Benefits

An employee health care plan may offer additional services supplementing the required services, reduce or remove any limitation on the amount of these benefits, and reduce or eliminate the cost sharing requirements. Any additional benefits provided would not be subject to the general requirements of the program (except the disclosure requirements, discussed later). The employee is not required to accept (or contribute toward) any additional benefits but could elect only the required benefits of the program.

Administration

The employer must inform his employees of the availability of his plan, its benefits, and its other provisions. He is forbidden by law to require the employee to forego participation in the plan as a condition of employment, to offer financial inducements to do so, or to offer an unapproved plan to his employees. Further, an employer may not discriminate in hiring, or in conditions of employment, because of the employee's health condition or that of his dependents (unless required by the nature of the job).

An employer could meet his obligations to provide an employee health care insurance plan by purchasing a health insurance policy insured by a carrier or providing a self-insured health plan. He could also provide the required health insurance by enrolling his entire employment group in the assisted health care insurance plan, as described later. (The bill also includes special provisions concerning prepaid plans, also described later.)

A recognized union or other bargaining agent could select, on behalf of the employees it represents, the options available on coverage (including choice of plan, decisions on additional coverage, and similar matters).

Any employed member of a family eligible under the coverage provisions of the law could take out a family policy covering the employee and eligible dependents.

Compliance and Approval

The Federal Government may require an employer to provide information concerning his compliance with the law, and could bring suit in Federal court to enforce the coverage and other provisions. An employee could also bring suit against his employer to obtain compliance.

The employee health plan must be approved by the State and the health insurance carriers and providers of service must be qualified under the program, as described later.

Financing

The employer must contribute at least 75 percent of the premium cost of the required health care insurance plan, but 65 percent for the first 3 years of the program. Employees must contribute the balance of the premium for the required insurance coverage.

If the employee elects to accept better coverage offered by his employer plan, he can be required to pay an additional premium. In any case, the contributions for better coverage and in fact the employer contributions (above that required by law) could be arranged or negotiated between employers and employees, as under present arrangements.

Premium rates would be set for an individual policy and for a family policy, with the individual rate being 40 percent of the family rate. No other variations in premium rates by family size or composition would be permitted. A family policy could include the husband and wife, their dependent unmarried children, and dependent parents living in the employee's residence (but not aged persons eligible under the Federal program).

Amount of Premium

The amount of the total premium would be negotiated between the insurance carrier and the employer. In general, the premium rate for large group insurance plans is based on the cost of benefits under the plan, a method of calculating called experience rating. However, experience rating is usually not used for small groups, but rather a variety of other rating methods are used. For firms with very few employees, perhaps just 1 or 2, group rates are often not available.

Under the proposal, all carriers who wish to sell approved coverage to employers with fewer than 50 employees must make coverage available to all such small employers in the State, and must charge them the same individual and family premium rates.

Under the proposal, that part of the premium rate applicable to benefits for persons who incur more than $10,000 annually in covered expenses for required benefits could not be included in the experience rating formula for a particular employer, but must be the same for all of a carrier's approved employee plans in the State (that is, averaged over that carrier's Statewide health insurance business).

The Department of Health, Education, and Welfare (DHEW) has estimated the national average premium rate for a required benefit plan at $600 annually for a family policy and $240 for an individual policy, at 1975 levels.

Federal Subsidy

If, as a result of the requirement to offer coverage, an employer's premium contributions increase his payroll by more than 3 percent, the Federal Government would pay a subsidy covering part of the excess over the 3 percent. The subsidy would be available for the first 5 years of the program, as follows:

Year of program	Percent of excess covered by subsidy
First	75
Second	60
Third	45
Fourth	30
Fifth	15
Sixth	No subsidy

The availability of the subsidy and its amount would be based on an employer's Statewide payroll and premium costs.

ASSISTED HEALTH CARE INSURANCE PLAN

The assisted plan is designed to make health insurance coverage universally available to all persons not otherwise insured against the costs of health care. The plan would be administered by the States through private carriers and financed by premium contributions from covered persons, and from Federal and State general revenues. It would cover the same health services as the employee plan, but with cost sharing and premiums varied according to family income.

Coverage

All individuals and families would be eligible to enroll in the assisted plan except (1) workers eligible for an employee plan with income over

specified levels--namely, $5,250 for an individual and $7,500 for a family--and (2) aged persons eligible under the Federal health care insurance program.

Also, as indicated, an employer could meet his obligations to provide coverage under an employee health care insurance plan by insuring his entire employment group under the assisted plan (but, at relatively high premium rates). A worker in such an employment group under the assisted plan could elect out of the group and enroll in the assisted plan on a personal basis, for himself and his family. As discussed later, the provisions for cost sharing, premiums, and continuation of coverage under the assisted plan differ for workers who are part of an employment group and those enrolling on a personal basis.

While the eligibility provisions are relatively broad, the desirability of electing the assisted plan (as opposed to obtaining coverage under another approved plan or under a private plan) depends on the premium, benefits, and cost sharing provisions of the plan, and on the employment, income, and health characteristics of the persons or groups involved. A discussion of the persons and groups eligible for coverage under the assisted plan who would be expected to elect the plan is given later, after further description of the provisions of the plan.

Continuation of Coverage

As under the employee plan, coverage for workers in employment groups enrolled in the plan could continue for 180 days after termination of employment, with the employer required to contribute toward the premiums for the first 90 days.

Benefits

The health services covered under the assisted plan would be the same as those under the employer plan, but the cost sharing would vary according to family income. For the assisted plan, a family is defined to include the husband and wife, dependent unmarried children, and dependent parents living in the same household (but excluding any aged persons eligible for the Federal program). Family income could include income from all sources, but will be defined by DHEW regulations.

For cost sharing purposes, individuals and families would be classified in five income classes. The highest income class (class 5) consists of individuals with annual incomes of $7,000 and over and families with $10,000 and over. The income limits for the other four classes are calculated as a percentage of the class 5 income (namely, under 100 percent, 75 percent, 50 percent, and 25 percent, respectively). However, all individuals and families in employment groups under the assisted plan would be included in class 5. The income class limits and cost sharing provisions are shown in table 2.

TABLE 2.--Assisted Health Insurance Plan: Income classes and cost sharing requirements

Income class	Income limits	Deductibles		Coinsurance rate	Maximum family liability	
		Regular	Drug		Percent	Amount
Individuals						
1	0-under $1,750	0	0	10	6	0-under $105
2	$1,750-under 3,500	$50	$25	15	9	$158-under 315
3	3,500-under 5,250	100	50	20	12	420-under 630
4	5,250-under 7,000	150	50	25	15	788-under 1,050
5	7,000 and over	150	50	25	---	$1,050
Families						
1	0-under $2,500	0	0	10	6	0-under $140
2	$2,500-under 5,000	$50	$25	15	9	$225-under 450
3	5,000-under 7,500	100	50	20	12	600-under 900
4	7,500-under 10,000	150	50	25	15	1,125-under 1,500
5	10,000 and over	150	50	25	---	$1,500

Cost Sharing Provisions

The cost sharing provisions for class 5 are the same as for the employee health care insurance plan. For class 4, they are also the same, except that the maximum family liability is limited to 15 percent of income.

For income classes 1, 2, and 3 all of the cost sharing requirements are reduced. The reduction in the deductibles is calculated as a percentage of the maximum deductibles (namely, for classes 1, 2, and 3, the regular deductible is 0, 33, and 67 percent, respectively, of the maximum deductible; for the drug deductible, the corresponding percentages are 0, 50, and 100 percent, respectively). The reduced coinsurance rates and maximum family liability rates (after which no cost sharing is required for any members of the family) are specified in the law (table 2).

The initial income classes would be applicable for the first 2 years of the program. Each year thereafter, the class 5 income limit (called the income class base) would be increased according to the rise during the year in average earnings as shown in social security earnings records, with proportionate increases made in the other income class limits.

The initial cost sharing provisions would also apply during the first 2 years of the program. Each year thereafter, the amount of the maximum deductibles would be increased to the same amounts applicable to the employee plan (rather than based on the assisted plan), and proportionate increases made in the deductibles for the lower income classes.

Cost sharing under all plans of the program would be combined to determine when the deductibles and maximum family liability limits are met.

Administration

The assisted plan would be administered by the States under regulations established by the DHEW. Each State would submit its State assisted health insurance plan (which would include the provisions concerning eligibility, premium amounts, cost sharing requirements, and related matters) to the DHEW which would approve qualified plans and designate the State agency responsible for its administration. The DHEW approval may later be withdrawn if a State plan no longer complies with the law, or is administered in a way which results in noncompliance. If a State plan is not approved or approval is withdrawn, Federal payments would be withheld for the plan, or for the parts of it not in compliance. Disapproval of plans is subject to hearings and review by Federal courts.

The State of residence of eligible persons would be determined under regulations of the DHEW which would be designed to assure that coverage is available for migrant farmworkers and others who frequently move from State to State.

The States would contract with private insurance carriers to act as their agents to administer the insurance provisions of the plan. The carriers would be reimbursed for their administrative costs, but would not underwrite the insurance. Debts resulting from the failure of enrollees to pay premiums or cost sharing would be considered debts to the State rather than to the carrier. The State must assure confidentiality of information held by carriers about persons enrolled with them.

As an alternative, the States could administer the entire program themselves, without carriers, if authorized by the Department.

Financing

The costs of the assisted insurance plan would be financed by premium payments from enrollees, with the balance shared by State and Federal Government general revenues.

In calculating premiums, a two-rate premium structure would be used, as for the employee plan, with the rate for individuals 40 percent of the family rate. The premium rates would be based on the average premium for employee health care insurance plans in the State (rather than on the costs of the assisted plan) with the maximum premium set at 150 percent of the employee-plan premium.

The premium rates for enrollees (not in employment groups) in the plan would be based on their income class, as shown below. The amount of the premiums shown here are based on estimated national averages for 1975, and there would of course be variations among the States.

Income class	Percent of average employee-plan premium	Amount of premium	
		Individual	Family
1.....	0	0	0
2.....	0	0	0
3.....	50	$120	$300
4.....	100	240	600
5.....	150	360	900

For employment groups brought under the assisted plan by the employer, the premium contributions would be the maximum contribution--that is, the rate for class 5. As for employee plans, the employer would be required to pay at least 65 percent, initially, and later 75 percent of the total premium. The employee would pay the balance.

Where an employee has elected the assisted plan in lieu of his employer's health care insurance plan, the employer concerned would contribute to the assisted plan the same premium required under his own plan. The employee would contribute according to his income class.

State Contributions

The amount of the State contribution to the plan in a year would be determined by a formula based on (1) the State's ability to pay as measured by State per capita income compared with national per capita income, (2) the amount of benefits paid for services under the State assisted plan, and (3) the level of State expenditures under Medicaid, in the year before the program becomes effective, for these types of health services covered by the new program. The formula is designed to result in the States paying about one-quarter of the total Federal-State cost of the program, with the proportions varying according to State per capita income. (For the first year of the program, before benefit data under the assisted plan are available, a special formula would be used.)

The State would not be permitted to impose any premium tax on premiums paid under the assisted plan.

Election of Coverage

Table 3 shows the distribution, by employment status, of persons and groups eligible to elect coverage in the assisted plan, and those actually expected to elect it. In this table, the term "employed" refers to workers who meet the requirements for coverage under an employee health care plan. The "not employed" group refers to all other persons, including part-time workers, the self-employed, the nonemployed, and others. The term "high health risk" indicates individuals or families in relatively poor health who could expect to pay the maximum cost sharing under various plans.

Employed persons eligible under an employee health care plan may find it advantageous to elect the assisted plan, rather than their employee plan, depending on their income level, because of the income-related premiums and cost sharing provisions of the assisted plan. If the workers or their family members are in poor health and expect to pay high cost sharing, the assisted plan becomes desirable even at higher income levels.

TABLE 3.--Assisted Health Care Plan: Individuals, families, and employment groups, eligible for coverage and expected to elect coverage, by income and risk groups

Group	Eligible for coverage	Expected to elect coverage	
		Average health risk	High health risk
Employed:			
Individuals.....	Under $5,250	Under $3,500	Under $5,250
Families.....	Under 7,500	Under 5,000	Under 7,500
Not employed:			
Individuals.....	All	Under 5,250	All
Families.....	All	Under 7,500	All
Employment groups....	All	None	All

For employment groups, the health status of the group is probably the most important factor, although the relatively high premium rates usually applicable to small groups would also be a consideration.

The nonemployed poor, many of whom are now under the Medicaid assistance program, would receive coverage under the assisted plan on a basis related to their family income.

For the other "not employed" such as the self-employed, disabled persons, and others not part of an employment group, coverage is now available usually only on an individual (nongroup) basis, at considerably higher premium costs than for groups. This factor, as well as income levels and health status, would influence their decision to elect the assisted plan or other coverage.

The data in table 5 on page 42, which shows the premiums, cost sharing, and maximum liabilities, by income class, for the three plans, may be useful in understanding further the considerations involved in decisions to elect coverage under the assisted plan.

FEDERAL HEALTH CARE INSURANCE PLAN

Like the present Medicare program, the Federal health care insurance plan would cover aged persons insured under social security and be financed mainly by a continuation of the present Medicare payroll taxes and premium payments paid by covered aged persons. The plan would provide the same health services as the other two plans and thus improve the benefits of the present Medicare program. The low-income aged would receive the advantages of reduced cost sharing and premium payments, with these additional costs financed by Federal and State general revenues. The plan would be administered in a manner similar to the present Medicare program.

Coverage

As indicated, like Medicare, the program would cover persons who are insured under the social security program. Under temporary transitional provisions, every citizen (or permanent alien resident) who has reached age 65 in the first year of the program would automatically be covered (blanketed in) under the plan. Also, in following years, eligibility would be extended to additional persons who have specified credits under social security, but not enough to meet the regular Medicare requirements. Under these provisions, a person would need 3 quarters of coverage for each year from the second year of the program up to the year he reaches age 65. (Social security credits acquired at any time would be counted.) The provision would "wash out" when its requirements became the same as the regular requirements for insured status under social security.1/

All Federal, State, and local government employees would become subject to the payroll taxes of the program and get credits toward coverage under the Federal program. The transitional provisions, described here, would of course assist newly covered persons to become insured under the program.

Persons age 65 and over not insured under the Federal plan could enroll under the assisted health care plan and would pay the cost sharing and premiums applicable to the assisted plan. Disabled persons who were brought under Medicare by P.L. 92-603 (H.R. 1) would not be included under the Federal plan, but most of these would be covered by the assisted plan.

1/ Under the regular requirements, a person needs 1 quarter of coverage for each year after 1950 (or if later, the year he attains age 21) up to the year he becomes entitled to benefits. A person who has 10 years (40 quarters) of coverage is fully insured for life.

Benefit Structure

As indicated, the plan for the aged would cover the same health services as the other plans. Each aged person would be treated as an individual (regardless of family status) for cost sharing purposes and would pay the same amounts of cost sharing--amounts generally less than those required for individuals with comparable income under the assisted and employee plans. However, the low-income aged (those in classes 1, 2, and 3) would have the advantages of reduced cost sharing. These cost sharing provisions are shown in table 4. As for other plans, cost sharing under all three plans would be combined for determining when deductibles and maximum liability are met.

Administration

The Federal plan would be administered by the DHEW in a manner similar to the present Medicare program under which the processing of claims is handled by private carriers under contract with the Department, and Medicare taxes are collected by the Internal Revenue Service.

For the Federal plan, determination of income would be tied administratively to the Supplementary Security Income (SSI) program established by P.L. 92-603 (H.R. 1).

Financing

The present Medicare hospital insurance tax levied on wages and self-employment income would be continued at the same tax rate and earnings base as scheduled under present law and, as indicated, would be extended to cover all Federal, State, and local governments and their employees.

Each aged person eligible for the program would be required to enroll as an individual and pay a premium. The premium rate, which would be the same for all persons, would be calculated as an amount equal to 15 percent of the average cost to the program for an aged person in class 4, estimated at about $90 at 1975 levels. However, the low-income aged, in income classes 1 and 2, would pay no premium.

General Revenues

Funds from Federal general revenues would be paid to cover the cost of benefits and related administrative expenses of persons who become eligible under the special transitionally insured provisions, described above. Also, Federal and State general revenues, shared according to the formula used for the assisted plan, would pay the additional costs resulting from the reduced cost sharing for the aged in income classes 1, 2, and 3, and reduced premiums for classes 1 and 2.

TABLE 4.--Federal Health Care Insurance Plan: Income classes and cost sharing requirements

Income class	Income limits	Deductible		Coinsurance rate	Maximum individual liability	
		Regular	Drug		Percent of income	Amount
Individuals						
1.....	0-under $1,750	0	0	10	6	0-under $105
2.....	$1,750-under 3,500	$50	$25	15	9	$158-under 315
3.....	3,500-under 5,250	100	50	20	12	420-under 630
4.....	5,250 and over	100	50	20	---	$750

All funds would be deposited and paid from a new Federal health care benefits trust fund.

The premium and cost sharing provisions for each of the three plans are summarized in table 5.

ADMINISTRATION AND REGULATION OF THE PROGRAM

The States would have responsibility under Federal rules or guidelines for administration of major parts of the program, including (1) the approval of employee and other related health plans, (2) certification and regulation of providers of service participating in the program, (3) determination of reimbursement rates for providers of service, (4) supervision of the reimbursement system, and (5) regulation of insurance carriers. Generally speaking, these provisions would apply to all three plans of the program.

The DHEW would review the State laws, regulations, and administration relating to these functions and certify States which are qualified under the law. The decision of the Department on certification would be subject to hearing and review by Federal courts. Unless a State is certified, none of the three plans of the proposed program would go into effect in the State (but the present Medicare program would continue there). Further, as indicated later, at the start of the new program, Federal funding for State Medicaid programs would end in all States for the health services covered under the proposed new program.

As one of the requirements for participation, States must permit individuals to bring suit in State courts to compel the State, carriers, employers, and providers to comply with the State laws and requirements.

Approval of Employee Plans

Carriers providing an employee plan are required to file the plan with the State, which must promptly determine if it is qualified. The requirement would apply to all types of employee plans, including carrier-insured and self-insured plans. The States' approval could later be withdrawn if a plan is changed and no longer meets the requirements, or is administered in a manner which results in noncompliance. The carriers and employers concerned would be promptly notified of the qualification status of their plan.

TABLE 5.--Administration Proposal: Premium rates and cost sharing requirements, by type of plan

Income class	Annual income	Amount of premium 1/	Cost sharing requirements (per person)			Maximum family liability 2/	
			Regular deductible	Drug deductible	Coinsurance rate	Percent	Amount
	Employee health care plan						
All individuals		$240	$150	$50	25	---	$1,050
All families		600	150	50	25	---	1,500
	Assisted health insurance plan						
Individuals							
1	0-under $1,750	0	0	0	10	6	0-under $105
2	$1,750-under 3,500	0	$50	$25	15	9	$158-under 315
3	3,500-under 5,250	$120	100	50	20	12	420-under 630
4	5,250-under 7,000	240	150	50	25	15	788-under 1,050
5	7,000 and over	360	150	50	25	---	$1,050
Families							
1	0-under $2,500	0	0	0	10	6	0-under $150
2	$2,500-under 5,000	0	$50	$25	15	9	$225-under 450
3	5,000-under 7,500	$300	100	50	20	12	600-under 900
4	7,500-under 10,000	600	150	50	25	15	1,125-under 1,500
5	10,000 and over	900	150	50	25	---	$1,500
	Federal plan for the aged 2/						
Individuals							
1	0-under $1,750	0	0	0	10	6	0-under $105
2	$1,750-under 3,500	0	$50	$25	15	9	$158-under 315
3	3,500-under 5,250	$90	100	50	20	12	420-under 630
4	5,250 and over	90	100	50	20	---	$750

1/ Total estimated national average premium at 1975 levels. For employee plan and, in some cases, for assisted plan, the employee and employer would share payment of the premium.

2/ Under Federal plan for the aged, eligible persons would be treated as individuals, regardless of family status.

Certification and Regulation for Providers of Service

Standards for Participation

The standards for participation by providers of service in the new program are similar to those of the present Medicare program. In addition, provision is made for expanded participation of optometrists and dentists who must be legally authorized to practice in their State. Chiropractors are excluded as providers. (Medicare standards are shown on page 225.)

The law provides for participation of physicians' extenders--including physicians' assistants, nurse practitioners, and similar personnel--in the program, and establishes the following standards for these personnel. The law also indicates additional standards could be set by regulation:

(1) They must perform services under the supervision and control of a physician, or act as his agent, and these services must be related to the supervising physician's type of practice.

(2) They must complete a training program, or pass a certification examination of an appropriate organization, or meet certain proficiency requirements--in all cases, as approved under DHEW regulations.

(3) The charges for their services must be included in the bills of the supervising physician or employing organization.

(4) The performance of the services must be legal under State law.

Disclosure for Providers

Under regulations to be established by the DHEW, providers of service must make available to persons seeking care information on (1) charges for common services, (2) hours of operation and other information about access to services, and (3) any license, accreditation, or certification held by the provider.

Control of Capital Expenditures

The bill incorporates the provisions of P.L. 92-603 (H.R. 1) which requires approval by the State planning agency of substantial capital expenditures in health care facilities. The present law, applicable to Medicare, Medicaid, and certain other federally aided programs, imposes penalties by excluding reimbursement for depreciation and interest from the payment for services provided by the disapproved capital improvement. The bill would greatly strengthen the penalty by eliminating the entire

payment for the services provided by the disapproved capital improvement. This new provision would apply to all plans of the proposed program as well as programs covered by present law.

Professional Standards Review Organization (PSRO)

The proposal incorporates the PSRO provisions of P.L. 92-603 (H.R. 1) for review of the necessity and quality of services under Medicare, Medicaid, and other programs, and extends these PSRO provisions to services under all three plans of the new program.

It also amends the PSRO law to require mandatory review of outpatient services. Under present law, review is only required for inpatient services and is optional for outpatient care. The new requirement would also apply to programs now subject to PSRO.2/

Reimbursement of Providers of Service

The States would establish rates of reimbursement for covered services for the three plans of the program, in accordance with procedures and criteria established by DHEW. These rates would be made publicly available.

Reimbursement System

Persons enrolled in all plans would be issued a health card, to identify them as enrolled under the program, and a health card account would be established for each enrollee. These accounts would be similar to accounts maintained by credit organizations and would serve as the basis for reimbursement of providers of service.

The account would serve as the vehicle for payments from carriers and other sources for reimbursement to providers of service. Providers who are participating in the program would be required to elect as either a full participating or an associate participating provider. All hospitals, skilled nursing facilities, and home health agencies must elect as full participating. The States would certify providers as qualified full or associate providers and make this information publicly available. Individuals could challenge the State certification in State courts.

2/ Unlike the other provisions discussed under this section on administration and regulation of the program, the PSRO provisions would not be a primary responsibility of the State.

Full participating providers must accept the State-established rate for a service as their full charge for patients under all plans of the program. The health card account would pay them the full established rate for their service, including the cost sharing due from the patient. Associate providers must also accept payment on this basis for patients under the assisted plan and the Federal plan for the aged. The account would collect the cost sharing from the patient who could pay on credit over a period and at interest rates indicated by DHEW regulations.

Associate providers could refuse to accept the established rate as full payment for employee-plan patients, and could charge the patient an additional fee or amount above that rate. In this case, the health card account would pay them only the covered (insured) part of the charges, at the established rate, and the provider would need to collect both the cost sharing and the additional fee directly from the patient.

However, an exception is made for pharmacies and other drug providers who, though certified as associate providers, would receive the established rate including the cost sharing from the health card account, and could collect additional charges from the patient. This special provision would apply to persons under all three programs. It would of course be expected that patients would tend to purchase from pharmacies which do not impose any additional charges.

Anti-Duplication

The bill permits coverage only under one approved plan and provides that, if a person is enrolled under more than one plan, only one of the plans would pay for any service, as determined by DHEW regulations.

Regulation of Insurers

The law would permit various types of organizations, including voluntary associations, corporations, and partnerships to qualify as approved health insurance carriers. The organization could be one which pays for or provides health services under group insurance policies, hospital or medical service agreements, or membership or subscription contracts.

Employers who self-insure on a qualified basis, and pay for or provide health services directly for their employees, could also participate as approved carriers.

The States would be required to regulate and enforce the following requirements of the Federal law for carriers of all types, but could impose more stringent requirements if they wished:

(1) The carriers would be required to file with the State a statement of rates or rating formulas (referred to as "file and use" procedures) for each approved employee plan. The statement must include sufficient information to permit the State to determine if the rates are reasonable in relation to the benefits provided and the State could disapprove or suspend rates considered unreasonable.

(2) An annual audit of each carrier must be conducted by a certified public accountant (CPA) and the reports made public.

(3) Upon request, the carrier must disclose to persons to whom a plan is offered, the plan's (a) benefits and exclusions, (b) premium rates, and (c) the percentage of the premiums expected to be paid in benefits.

The States must also determine the adequacy of the carriers financial condition to meet their obligations and, if a carrier is found to be financially insolvent or impaired, must assure that the carriers obligations will be met--by being paid in full, guaranteed, assumed or reinsured. This requirement could be implemented under an insolvency or guarantee fund or other means established or regulated by the State.

Reporting and Evaluation of the Program

The DHEW would establish requirements for reporting of information necessary to enable it to monitor and evaluate the program, as follows:

(1) Employee health care plans are required to maintain uniform statistical methods and procedures and to report information requested by the Department.

(2) States are required to report information requested by the Department concerning the State assisted plan.

(3) States are required to report to the Department on their activities concerning approval of health care plans, establishment of reimbursement rates, certification of providers, and regulation of providers of service and insurance carriers.

Each year the Department would prepare a report to the President, for transmittal to Congress, which would include a summary of its activities concerning the program, appraisal of the adequacy of the program and, if any, recommendations for additional legislation.

Relationship to Other Government Programs

Federal funds for State Medicaid programs would be limited to the following services: (1) intermediate care facilities, (2) skilled nursing facilities for persons age 21 and over, (3) home health services, (4) care in mental institutions for persons under age 21 and over age 65, and (5) medical or remedial care for persons in a medical institution, or needed to reduce the need for such institutionalization. In all cases, covered health services, cost sharing, or premiums under the new program could not be included for Federal matching funds.

The new program would not pay for services covered under workmen's compensation laws. The health insurance program for Federal employees and retirees and the health programs of the Veterans Administration, the Indian Health Services, and other Federal programs for special groups would continue to operate. The Administration has announced its intention of proposing legislation concerning the relationship of these special Federal programs with the proposed new program.

PREPAID HEALTH PLANS

The proposal establishes requirements for participation under the program of prepaid health plans and includes special provisions designed to facilitate and encourage enrollment in these plans.

Employee Health Care Plans

All employers required to offer their employees a health care plan must offer a choice of (1) a health care insurance plan, as described earlier in the discussion of employee plans, (2) a group practice prepaid plan, or (3) an individual practice prepaid plan. The need to offer prepaid plans may be waived if they are not available in the community, as decided by DHEW regulations.

To qualify as an employee plan, the prepaid plan must be approved by the State (like other employee plans) and must meet the general requirements for employee plans including continuation of coverage, anti-duplication provisions, a two-rate premium structure, and reporting requirements to DHEW.

For an employee who elects a prepaid plan, the employer is required to contribute at least 75 percent (initially 65 percent) of the premium cost of the required basic health insurance plan (that is, the same amount he contributes toward basic benefits under his employee insurance plan). If the prepaid plan charges a higher premium, the employee can be required to pay the additional amount.

Assisted Plan and Federal Plan for the Aged

Persons eligible under the assisted plan would also have the option of electing coverage under an approved prepaid health plan as an alternative to coverage under the regular State assisted health care insurance plan. If so, the State would pay the prepaid plan a capitation amount equal to the average cost of coverage under the regular State assisted health insurance plan. Any additional premiums charged by the prepaid plan would be paid by the enrollee.

Similarly, persons eligible under the Federal health care insurance plan could enroll in a prepaid plan, in which case the Federal program would pay the prepaid plan a capitation amount equal to the average cost of the Federal program, and the enrollee would pay any additional premium required by the prepaid plan.

Requirements for Prepaid Plans

To be approved under the program, prepaid health plans are required to meet the general requirements of the program and certain special requirements. As a participating provider of service, it must meet the certification standards and regulations applying to providers, described earlier, and, if it acts as its own carrier, any regulations established for them as insurance carriers. In addition, group practice plans must meet the following requirements of the law:

(1) They must provide, or arrange for, all the required health services under the program, but may vary or remove the cost sharing and limitations on these benefits.

(2) The plans must be reimbursed by means of a predetermined (capitation) rate for all their services, except that they may impose copayments as authorized by DHEW regulations.

(3) They must provide physicians' services through physicians who are employees or partners of the plan, or through arrangements with physicians' groups engaged in the coordinated practice of their profession.

(4) The plans must be organized in a manner so that (a) they bear responsibility for the efficient and effective use of health resources, (b) the components affiliated with the plans share that responsibility, and (c) they provide a clear focal point of responsibility.

An individual practice plan must meet the same requirements as a group plan except that physicians' services would be provided through arrangements with physicians practicing on an individual practice basis (rather than as indicated in item 3 above).

ULLMAN BILL

The "National Health Care Services Reorganization and Financing Act" was introduced by Representative Al Ullman of Oregon as H.R. 1. It is supported by the American Hospital Association.

General Concept and Approach

The proposal would establish a three-part national health insurance program including (1) a plan requiring employers to provide specified private health insurance for their employees and their families, (2) a plan for individuals, and (3) a federally financed plan providing health insurance for aged, low-income, and medically indigent persons administered through Federal contracts with insurance carriers. The benefits of all plans would be the same.

The State governments would have major responsibility for administering the health insurance program and regulating providers of service and insurance carriers, in accordance with Federal rules. The State would also incorporate and regulate a system of health care corporations which would provide (through their own facilities or affiliated providers) comprehensive health care services to an enrolled population in designated geographical areas.

REQUIRED COVERAGE OF EMPLOYERS

The plan requiring employers to provide specified health insurance coverage for their employees would provide a broad range of services, generally subject to cost sharing by the patient. Additional catastrophic benefits would become payable when expenses exceed a specified amount. Coverage would be purchased from private insurance carriers, with the premium cost shared by employers and employees. Federal subsidies and tax deductions would be available under certain circumstances.

Coverage

The coverage requirement would apply to all employers subject to the social security tax including nonprofit organizations and other employers who have elected social security on a voluntary basis. It would not apply to Federal, State, and local governments as employers, nor to employees enrolled under federally contracted insurance (described below). Where two or more members of the family are employed (or an individual has more than one employer) coverage would be provided by the employer paying the highest wages.

The participation of employees would be voluntary. Employed persons eligible for an employee-employer plan are not eligible under the federally financed plan (for the aged, low income, and medically indigent) even though they meet the requirements of the Federal plan.

Coverage under the employers plan would be continued for 14 days for employees whose job is involuntarily terminated, but would cease when the employee became eligible for unemployment insurance. Coverage for workers receiving unemployment insurance would be provided through the Federal-State unemployment insurance system. Also, without regard to the cause of termination of employment, coverage would be available at the option of the employee for a period of 30 days, with the employee paying the entire premium.

Self-Employed Persons and Others

Coverage under the proposal would be made available on a voluntary basis at reasonable group rates to self-employed persons and other individuals (not eligible for federally contracted coverage). The arrangements for this coverage would be made by the States in accordance with Federal regulations.

Benefit Structure

The required benefits of the program would be phased in in two stages with the initial benefits effective 6 months after enactment of the bill and the regular ones (referred to as comprehensive health care benefits) 5 years after enactment.

The timing of covered benefits are shown in table 1 and the benefit provision in table 2. The comprehensive health care benefits include catastrophic expense benefits, but the latter are shown in a separate column in table 2 because (as explained later) they would also be applicable to the initial benefits. Approved plans may include additional benefits (or eliminate or reduce the cost sharing) but these are not subject to the requirement or subsidies of the program.

Most benefits are subject to cost-sharing provisions requiring the patient to pay a flat dollar copayment or a percentage of the charges. The amount of the flat copayments would be increased, if the Consumer Price Index for a year rises by 3 percent or more over the previous year, at the same rate as the rise in the price index.

The nature of the health examination benefit, which is not specified in the bill, would be established by regulation. The bill states that consideration be given to providing the following:

TABLE 1.--ULLMAN BILL: Effective date of benefits

Group	Type of benefits and effective date		
	6 months 1/	3 years 2/	5 years 3/
General population:			
Employees.....	Medicare benefits Catastrophic expense		Comprehensive health care
Self-employed and others.....	Medicare benefits Catastrophic expense		Comprehensive health care
Persons receiving unemployment insurance.....	Medicare benefits Catastrophic expense		Comprehensive health care
Federally contracted insurance:			
Aged.....	Medicare benefits: Automatic coverage under Part B Catastrophic expense for low-income group	Catastrophic expense for all	Comprehensive health care
Low-income.....	Medicare benefits, with no cost sharing		Comprehensive health care
Medically indigent	None	Medicare benefits Catastrophic expense	Comprehensive health care

1/ Effective at the beginning of the first calendar or fiscal year which occurs 6 months after enactment.
2/ Effective at the beginning of the first fiscal year which occurs 3 years after enactment.
3/ Effective at the beginning of the first fiscal year which occurs 5 years after enactment.

TABLE 2.--ULLMAN BILL: Initial, comprehensive health care, and catastrophic expense benefits

Type of service	Initial (Medicare) benefits		Comprehensive health care benefits			Catastrophic expense benefit
	Benefit (in benefit period)	Cost sharing	Benefit (in benefit period)	Cost sharing	Other information	
Institutional services						
Hospital inpatient	90 days (plus 60-day lifetime reserve).	Deductible and coinsurance after 60th day.1/	90 days	$5 per day	Special provision for mental illness, alcoholism, and drug abuse.	No cost sharing, no limit on days.
Skilled nursing facility	100 days 2/	Coinsurance after 20th day.1/	30 days	$2.50 per day	Available after hospital stay of 3 days or more.	No cost sharing.
Nursing home	No benefit		90 days	$2.50 per day		No cost sharing.
Personal services						
Physicians' services:						
In home, office, and outpatient center	No limit	$60 deductible, 20 percent coinsurance.3/	10 visits per year.4/	$2 per visit.4/	Special provisions for mental illness, alcoholism, and drug abuse.	No cost sharing, no limit on visits.
In hospital and other institution	No limit	$60 deductible, 20 percent coinsurance.3/	No limit	$2 per visit.4/	Copayment applies only to attending physician.	No cost sharing.
Diagnostic services	No limit	$60 deductible, 20 percent coinsurance.3/	No limit	20 percent	No cost sharing for enrollees of health care corporations.	No cost sharing.
Health examinations	No benefit		By regulation	None		
Immunizations	No benefit		No limit	None		
Well-baby care	No benefit		(Per year)			
Under age 1			8 visits	None		
Age 1 to 2			4 visits	None		
Age 2 to 5			2 visits	None		

See footnotes at end of table.

TABLE 2.--ULLMAN BILL: Initial, comprehensive health care, and catastrophic expense benefits--Continued

Type of service	Initial (Medicare) benefits		Comprehensive health care benefits			Catastrophic expense benefits
	Benefit (in benefit period)	Cost sharing	Benefit (in benefit period)	Cost sharing	Other information	
Personal services--Continued						
Home health services	200 visits 2/	None	100 visits per year.	$2 per visit		No cost sharing.
Dental services (for children):						
Examination and cleaning	No benefit		1 visit per year	None	For children up to age 7; once child is covered, benefits continue to age 12.	No cost sharing.
Other services	No benefit		Routine dental care, by regulation.	20 percent		No cost sharing.
Vision services (for children):						
Examination	No benefit		1 visit per year	None	For children up to age 12; includes services of physician or optometrist.	
Eyeglasses	No benefit		1 set per year	20 percent		
Other services and supplies						
Prescription drugs	No benefit		Drugs necessary for specified conditions requiring expensive drug therapy, or especially important to the public health; by regulation.	$1 per prescription.	List of drugs to be shown by generic names.	No cost sharing.
Prosthetic devices	By regulation	$60 deductible, 20 percent coinsurance.3/	By regulation	20 percent	May include hearing aids.	No cost sharing.
Medical equipment	By regulation	$60 deductible, 20 percent coinsurance.3/	By regulation	20 percent		No cost sharing.
Ambulance services	No limit	$60 deductible, 20 percent coinsurance.3/	No limit	20 percent	Only when medically necessary.	No cost sharing.

1/ The Medicare hospital deductible for 1974 is $84. The hospital coinsurance rate after 60 days is one-quarter of the deductible ($21) and, for the lifetime reserve, one-half ($42). For skilled nursing facilities, the rate is one-eighth ($10.50). The amount of the deductible is raised each year if the per diem cost of inpatient hospital cost increases.

2/ Skilled nursing care and 100 home health visits are provided under Part A after a hospital stay of 3 days or more. Also, 100 home health visits are available under Part B with no coinsurance.

3/ The $60 deductible is a common deductible applicable to specified services.

4/ If a single combined change is made for services in and outside the hospital (e.g., for surgery or obstetrical care), the out-of-hospital visits would be exempt from the 10-visit limitation and coinsurance of 10 percent of charges would apply in lieu of the $2 copayment.

Age 5-18.....	One examination every 5 years
Age 19-64.....	One examination every 2 years
Age 65 and over.....	One examination each year

The regulations would also establish the services and diagnostic tests included in the health examination and these could be varied for different age, sex, and other patient groups.

The provisions for physicians services are defined to include services of allied health personnel under the supervision of a physician. Services of chiropractors are covered on the same basis as under the Medicare program.

Mental Illness, Alcoholism, and Drug Abuse

Special provisions would apply to care for mental illness, alcoholism, and drug abuse and dependence. Inpatient hospital care for these conditions is covered only if the condition is in an acute phase. Days of care are limited to 45 days (instead of the usual 90 days) but the special 45-day limitation would not apply to a patient enrolled in a health care corporation.

Outpatient care for these conditions is covered, subject to the usual 10-visit limit and copayment of $2 per day. (The copayment may be waived, by regulation, for treatment of drug abuse or dependency.) Day care and similar part-time services are specifically covered, subject to a limitation of 3 days of care substituted for each day of allowable hospital care. The bill states that the regulations governing the mental illness services should be designed to encourage the use of outpatient programs.

As under the present Medicare program, services in a skilled nursing facility would be available after a hospital stay of 3 days or more. The covered benefits also include nursing-home care (available without a previous hospital stay) which would provide a less intensive level of care (referred to as health-related custodial care) to patients with an incurable disease who are bedridden, require certain nursing procedures or meet other conditions.

Catastrophic Expense Benefits

The catastrophic expense benefits, which become effective after a specified expenditure by the patient for noncovered expenses, would liberalize the conditions applicable to the regular benefits. They would eliminate the cost sharing for all benefits and remove the limits on the number of (1) inpatient hospital days, except for care of mental illness, alcoholism, and drug abuse, (2) physicians' home, office, and outpatient visits, and (3) outpatient services for mental illness, alcoholism, and drug abuse.

The catastrophic benefits would be payable when specified noncovered medical expenses reach a certain total (the "expense limit"), which varies according to family income and age. The expenses that would be counted in determining this expense limit are (1) premiums paid for an approved health insurance policy, (2) expenses for cost sharing, and (3) expenses resulting from the limitation on the number of inpatient hospital days (except for mental illness, alcoholism, and drug abuse); skilled nursing facility days; physicians' home, office, and outpatient visits; and outpatient mental illness, alcoholism, and drug abuse services. Expenses incurred in the last 3 months of a year could be included in the next year's expense limit.

The family income classes (which are based on family size and income) used in determining eligibility for catastrophic benefits are the same as used in determining eligibility for federally subsidized health insurance (see page 57). A separate set of expense limits is applicable to families under age 65, and those age 65 and over. For the lowest income class, the expense limit is, in effect, zero and the catastrophic benefit is always in effect. The expense limit for the highest income class is not specified, but is calculated as 10 percent of income. The expense limits are as follows:

Income class	Expense limit	
	Under age 65	Age 65 and over
1	0	0
2	$250	$125
3	500	250
4	750	375
5	10 percent of income	

Initial Benefits

The initial benefit provisions would provide the same benefits as the present Medicare program. In addition, catastrophic expense benefits (similar to those described above) would be provided; they would remove the cost sharing, and the limitation on hospital days, applicable to Medicare benefits (tables 1 and 2).

Administration

The employer would purchase private health insurance for his employees from an insurance carrier qualified under the program. Also a health insurance plan must meet certain requirements to be eligible for the 10-percent subsidy available to enrollees of a health care corporation and similar approved organizations. The qualifications and requirements for carriers are described later.

Financing

The employer is required to pay at least 75 percent of the premium cost, and the employee the balance. Employers would receive subsidy payments from the Federal Government if their share of the premiums exceeds 4 percent of the average wages paid to employees. The subsidy would be equal to the amount of the excess, for a maximum of 10 employees. The coverage for persons receiving unemployment insurance would be financed by the Federal Government.

If an employed person was also eligible for the federally financed plan and his share of the premium contribution was larger than under the Federal plan, he would receive a subsidy from the Federal Government equal to the difference.

The premium for coverage for self-employed and other persons would be paid by the policy holder.

10-Percent Subsidy

Covered employees, self-employed, and other persons would receive a Federal subsidy if the family is (1) registered with a health care corporation, (2) enrolled in another organization providing comprehensive services to a defined population group through open enrollment, approved by the Department of Health, Education, and Welfare. The amount of the subsidy would be 10 percent of the group premium for covered benefits.

Income Tax Deduction

Under present law, persons who itemize their deductions on their individual income tax return may deduct one-half of their premium for private health insurance, up to a maximum of $150, as a medical expense deduction. Under the bill, persons who itemize could take their entire premium contribution for an approved plan as a deduction.

COVERAGE OF AGED, LOW INCOME, AND MEDICALLY INDIGENT

The Federal Government would provide health insurance coverage for the aged, low-income, and medically indigent groups through contracts with insurance carriers. The permanent benefits would be the same as under the required employer plans, although the interim benefits would be phased in differently. The benefits would be financed from the present Medicare payroll tax, Federal general revenues, and premium contributions from the medically indigent.

Coverage

Aged persons (65 and over) would be eligible for Federal coverage without regard to income, and eligibility for low-income and medically indigent individuals and families would be based on family income and size shown as follows:

Income class	Family size and income			
	Single individual	Family of 2	Family of 3	Family of 4 or more
1...	$0-$2,000	$0-$3,000	$0-$4,500	$0-$6,000
2...	2,001- 3,000	3,001- 4,500	4,501- 6,000	6,001- 7,500
3...	3,001- 4,500	4,501- 6,000	6,001- 7,500	7,501- 9,000
4...	4,501- 6,000	6,001- 7,500	7,501- 9,000	9,001-10,500

Note: Families are defined as parents and dependent children under age 19.

The families in class 1 are defined as the low-income group and those in classes 2, 3, and 4 as the medically indigent. The determination of income would be based on the adjusted gross income shown on the income tax return, but specified kinds of income could be included or excluded, as determined by regulation, if they are considered as readily available for living expenses (or not so). Also income could be determined on a more current basis if necessary to prevent hardship.

The dollar amounts shown in the table would be increased, if the Consumer Price Index in a year rises by 3 percent or more, at the same rate as the index.

Benefit Structure

The federally contracted insurance would provide the same permanent benefits subject to the same conditions as are applicable to employed persons, and these would also begin 5 years after enactment of the bill (tables 1 and 2). The catastrophic benefits would also be payable according to the income class and age; the table of expense limits is repeated as follows:

Income class	Expense limit	
	Under age 65	Age 65 and over
1	0	0
2	$250	$125
3	500	250
4	750	375

Initial Benefits

The initial benefits for the three groups under federally contracted insurance would be phased in, as described below (table 1).

Aged.--Under the present Medicare law, all qualified aged persons are automatically covered for hospital insurance benefits (Part A), but enrollment for supplementary medical insurance (Part B) is voluntary and requires payment of a premium. Under the proposal, beginning 6 months after enactment, all of the aged would automatically be covered under medical insurance and the premium would be eliminated. At this time, the aged who qualify as low-income persons would also receive catastrophic expense coverage (which would eliminate the cost sharing and hospital limitations of the Medicare benefits). Three years after enactment, all of the aged would be eligible for catastrophic expense coverage.

Low income.--Six months after enactment, low-income families would become entitled to the same benefits as provided under the Medicare program, with no cost sharing required (but with the limits on the number of hospital days retained).

Medically indigent.--The medically indigent families would first become eligible for benefits 3 years after enactment, at which time they would receive Medicare benefits supplemented by catastrophic expense coverage.

Financing

The aged and low-income groups would not pay any premium for the Federal coverage. The medically indigent would pay an annual premium, according to their income class, as shown below. The amount of this premium contribution would be raised, if the Consumer Price Index in a year rises by 3 percent or more, at the same rate as the rise in the index.

	Individual	Family
Class 2	$50	$125
Class 3	100	250
Class 4	150	375

Other Sources of Funds

The payroll tax levied to finance the benefits of the present Medicare program would continue. All additional costs of the program would be appropriated from Federal general revenues.

The amount of general revenue needed to finance the program (including the cost of the federally contracted insurance, the 10-percent subsidy described previously, and the administrative costs of the program) and to establish a 5-percent reserve would be estimated by the Department of Health, Education, and Welfare. The estimate would be based on past experience and expected changes in the cost of services, the number of low-income and medically indigent persons, the utilization of health services, and the amount of contributions from the medically indigent.

The Medicare trust funds would be retained and would receive the proceeds from the Medicare tax and the general revenues applicable to the aged (except the additional cost for their catastrophic coverage). All other funds would be paid directly from general revenues.

Administration

The Federal Government would contract with insurance carriers for health insurance for persons eligible for Federal coverage. The carrier must be one qualified to issue subsidized insurance plans (as explained later) and could include carriers underwriting a health care corporation or a corporation, operating on a capitation basis, acting as its own carrier.

The negotiation of the contract would not necessarily be subject to competitive bidding and other standard Federal contract requirements, but information about the proposed contract would be made available to all carriers. Contracts with more than one carrier could be made to provide coverage in an area. Also, a contract could require a carrier to subcontract the insurance with other carriers, or a contract could be made with a combination of carriers (which have established a joint arrangement or organization for this purpose). The Federal Government could use the State as its agent in negotiating contracts.

Enrollment

The conditions for enrollment under the plan would be prescribed by Federal regulations. Open enrollment periods would be held (which would be concurrent for the various carriers and corporations offering federally contracted plans in an area).

Federal regulation would determine the method of payment of premiums by the medically indigent (which could be direct to the carrier, the State commission, or other methods). As prescribed by regulations, a grace

period of not more than 90 days would apply in event of nonpayment of premiums before the insurance could be terminated.

Relationship to Other Government Programs

The Medicare program for the aged would be replaced by the new program. Federal financing for the Medicaid program would eventually be limited to services not covered under the new program (but would remain in effect for various population groups and services during the phasing-in period). Federal regulations would establish a new minimum scope of services required under a State Medicaid program, in lieu of the services required under present law, and these would be designed to supplement the benefits under the proposal.

Federal financial assistance under the Maternal and Child Health Program would be limited to noncovered services for persons covered by federally contracted insurance.

ADMINISTRATION AND REGULATION OF THE PROGRAM

The proposal would place major responsibility for administration of the program, in accordance with Federal regulations, on the State. The major provisions relating to State administration of the program would be presented in the State health care plan which would include the regulations for providers of service and insurance carriers and the provisions for establishment and supervision of a system of health care corporations.

Federal Administration

The primary Federal responsibility for the program would be lodged in a newly created department of health and all health programs of the Department of Health, Education, and Welfare (and certain health programs of other departments) would be transferred to this new department. The department would be responsible for the establishment of Federal regulations, review of State compliance with the program, evaluation of the program, and annual reports to the President.

A national health services advisory council of 20 members, appointed for 4-year terms, would include representatives of providers of services and consumers (with the latter to constitute at least one-half its members). The council would advise the department on policy, including prior review and comment on proposed regulations. It would make an annual report to the department and the Congress. The department would be required to report to Congress its views on recommendations about administration (if not adopted), and on the council's legislative recommendations.

State Administration

State responsibility for the programs would be placed in an independent State health commission, composed of three or five members appointed by the Governor for 6-year terms (with a maximum of two or three members, respectively, from the same political party). Representatives of the health care professions could not constitute a majority of the members. Members would be full-time employees, could not hold a financial interest in a health care provider, and could be removed only for cause.

The commission would be advised by a State advisory council which would include representatives of providers (including health care corporations, other providers, professional organizations and societies, and medical schools) and of consumers, with the latter constituting at least one-half the membership.

State Health Care Plan

The State health care plan would be developed by the commission, in consultation with the advisory council, after giving the general public an opportunity to present its views. The plan would need to be approved by the Federal Government. Disapproval would be subject to a hearing and review by Federal courts.

If the State failed to obtain an approved plan within 3 years after enactment of the bill, the Federal Government could intervene and administer the program in the State. It could also intervene if the approved plan is not properly administered, or is later modified, so that it is no longer in compliance with law.

Federal grants would be available to cover the entire cost of developing a State plan, and the following percentage of the cost of administering the plan:

90 percent for the year before benefits begin
85 percent for the first 2 years of program
75 percent thereafter

Reimbursement of Providers of Services

Payments to providers of service would be based on approved charges of providers, in accordance with Federal and State regulations. The Federal standards indicating the financial requirements of institutions and health care corporations, to be met by third parties, are as follows:

(1) direct and indirect patient expenses, including free services to indigents;

(2) expenses of approved education and research programs;

(3) working capital and interest;

(4) "price level depreciation" for assets (which takes account of rising prices, as opposed to historical cost depreciation);

(5) payments related to construction, modernization, and expansion of specified projects in years when expenditures for those projects exceed depreciation charges, provided that the total payments for the projects over their lifetime do not exceed the price level depreciation charges payable over their lifetime;

(6) a return on total assets based on rates of return for investments of comparable risks, to be included as a factor for developing prospective rates for proprietary institutions and for evaluating the financial requirements of nonprofit institutions.

For noninstitutional providers (professional and related), payments would be based on reasonable fees, salaries, or other compensation.

Approval of Charges

The State commission would approve charges for institutional providers based on a review of their budgets (prepared according to a uniform system of accounting) and a schedule of charges proposed by the provider. Charges for kinds of physicians' services provided in an institution which are generally available to all inpatients (such as radiologists and pathologists services) would be included in the institutions' budget and not as separate physicians' charges. Payment for unneeded services or for unapproved capital expenditures would not be allowed. Providers dissatisfied with the commission's decisions would be entitled to a hearing. The approved charge schedule would be applicable to all qualified private plans and to federally contracted coverage. The commission would also review charges of all licensed noninstitutional providers.

In general, the insurance carrier would pay the covered charges, and the patient would pay the cost sharing, to the provider. However, where a carrier insures a corporation which is not on a capitation basis, the carrier would pay the covered charge to the corporation and collect the cost sharing from the patient.

Standards for Participation of Providers

Standards for participation of providers would be established by Federal and State regulations. The minimum Federal standards for various types of providers indicated in the bill are as follows:

(1) hospitals, skilled nursing facilities, and home health agencies must meet the standards of the Medicare program (page 225)--as under Medicare, approval by State agencies or accreditation by certain national organizations would be accepted;

(2) skilled nursing facilities would need to be physically a part of, or in the immediate proximity to, a hospital and must be under the supervision of the professional staff of a hospital or have an organized medical staff;

(3) home health services must be furnished by a health care corporation (directly or through an affiliated provider);

(4) the use and qualification of paramedical personnel acting as assistants to physicians and dentists must meet Federal standards (the use of personnel according to these Federal standards can not be further restricted by State law).

Scope and Quality of Service

Providers of service would be required to comply with Federal and State standards concerning (1) the quality and, where applicable, the scope and comprehensiveness of services, (2) the control of the utilization of services, and (3) appraisal of the effectiveness of their services. For these purposes, the provider must establish systems of peer review, medical audit, and other procedures similar to the requirements for health care corporations, described later. The commission would review and approve peer review systems, and review the performance of providers in these matters.

Health Planning and Facilities

The commission would take responsibility for implementation and coordination of health facility planning (1) developed under the State health care plan; (2) State, regional, and local plans under the comprehensive health planning act; and (3) plans under other Federal or State programs.

Construction, modernization, or expansion of health care facilities or services by hospitals, skilled nursing facilities, nursing homes, or other organizations would not be permitted unless approved in advance by the commission.

On request of the Department of Health, Education, and Welfare, the State commission would review and recommend on applications of providers and other organizations for grants and contracts under various Federal laws, and act as its agent in enforcing compliance with Federal requirements.

Enforcement Powers

The commission could take corrective action against a provider of service which failed to fulfill its obligations, including suspension of payments for covered benefits (subject to hearing and court review).

Participating providers are prohibited, under penalty of Federal law, from soliciting or taking kickbacks or bribes in connection with covered services, or making rebates of fees or charges for referral of patients.

Regulation of Insurers

The commission would regulate health insurance carriers and approve carriers and insurance plans for participation in the program. Various kinds of organizations could qualify as an approved carrier, including organizations which pay for (or provide) health care on a group basis by contract, agreement, membership, or subscription arrangements; or a health care corporation acting as its own carrier.

Regulation of Premium Rates

The commission would be responsible for regulating the premium rates of carriers issuing qualified private plans under the proposal, but (except for health care corporations acting as its own carrier) regulation could be delegated to the State insurance department or other agency. Federally contracted plans would not be subject to State regulations.

Qualifications for Subsidized Insurance

An insurance plan, to be eligible for the 10-percent Federal subsidy (available for families enrolled in a health care corporation or similar approved organization), must meet the following requirements:

(1) provide coverage and benefits without regard to health status (such as preexisting conditions), economic status, race, sex, occupation, age, or any conditions indicated in regulations; classification of risks for the purpose of setting different premium rates would be permitted only according to actuarial principles;

(2) provide for coordination of duplicate coverage, as prescribed by Federal regulations;

(3) report to the Federal Government on financial matters, utilization of services, peer review of quality of services and other matter, as required by regulation, and make its records available for inspection;

(4) meet other requirements of the State plan.

Federal insurance contracts would be made only with carriers who are qualified to issue subsidized plans and meet any additional Federal requirements that may be established.

The State would be responsible for providing, by regulation, arrangements to assure all residents of the State an opportunity to obtain coverage. Carriers for federally contracted insurance must participate in a State coverage pool, if requested by the State.

Prospective Regulations

Amendments to the law or new regulations, enacted or issued in a year, which would affect the obligations or rights of carriers, would not go into effect until the following contract year (except where mutually agreed).

Evaluation of the Program

A national uniform statistical program would be established by the Federal Government. Each State commission would function as a center for the collection of health statistics and information, and providers and carriers would be required to report statistical information. (Safeguards would be provided to prevent disclosure of identifying information.)

As prescribed by Federal regulations, the commission would evaluate the health-related and economic effectiveness of its activities, and of health care corporations and other providers. The evaluation would include a comparison of utilization of services for health care corporations and for other providers. The evaluation and other reports required by regulation would be filed with the new department of health. At the Federal level, the department would evaluate the effectiveness of the program.

Disputes and Claims

The commission would settle disputes between individuals, providers, health care corporations, and insurance carriers by providing hearings before it in the following situations:

(1) claims by individuals against a provider or carrier (or vice versa) where the disputed amount is $100 or more;

(2) allegation by an individual of the failure of providers to meet their obligations, where the failure is part of a pattern of similar conduct;

(3) claims by a provider against a carrier for payment of charges for services (or for capitation charges);

(4) disputes between health care corporations and affiliated or nonaffiliated providers.

HEALTH CARE CORPORATIONS

A health care corporation is defined as a nonprofit or governmental organization which is organized to (1) furnish comprehensive and coordinated health services through its own facilities or affiliated providers, (2) conduct related educational, research, and other activities, and (3) provide adequate representation of its enrollees and affiliated providers on its governing board. The provisions and regulations for providers of service described above (and for insurance carriers where the corporation acts as its own carrier) would apply generally to corporations. Additional and specialized provisions applicable to corporations are described here.

Establishment of Corporations

The State commission would have responsibility for establishing a system of health care corporations in its State. It would assist organizations wishing to establish corporations by providing information, advice, and assistance in applying for Federal grants.

The commission would approve corporations to operate in specified geographical service areas. Service areas need not coincide with existing political boundaries and could extend across State lines, and the commission would assist in arranging with other States to establish joint areas. Organizations submitting applications for approval as a corporation would designate their preferred service area.

Applications for corporations would be evaluated according to the following criteria:

(1) the applicant's organization, management, resources, financial responsibility, and conformance with other requirements;

(2) the need for the proposed services in the area; and

(3) the need for an additional corporation.

If more than one application is pending, the applications would be considered simultaneously. The commission would consult with representatives of the public, providers, and government agencies before approving

corporations and their service areas. The commission (or another State agency) would incorporate approved organizations under State law. The initial approvals of corporations must be completed 4 years after enactment of the bill.

Enrollment

Periodic open enrollment periods would be held, with the conditions for enrollment determined by Federal and State regulation. At the start of the enrollment period, the corporation must provide full information to the public about its operations and services. It must enroll all persons living in its service area who apply, and could not discriminate (in enrollment or in providing services) on the grounds of race, creed, color, national origin, age, sex, occupation, economic status, or conditions of health. The corporation must make reasonable efforts to enroll persons assigned by the commission. An applicant who is not accepted could obtain a hearing before the commission.

Where the capacity of a corporation is limited, enrollment may be limited (with the approval of the commission) on a first-applied basis, but only if other approved corporations are available in the area. With the commission's approval, the corporation could enroll persons living outside its area and others it is not required to enroll. The corporation would assist eligible enrollees to obtain federally contracted coverage.

Medical Services

The bill states that the services of the corporation would, to the extent possible, (1) emphasize health maintenance and health education, (2) assure continuity of care and appropriate referral, (3) provide maximum care on an outpatient basis, (4) make services readily available, and (5) furnish outpatient care in places accessible throughout the area.

The corporation would be required to furnish to its enrollees all the hospital and medical services covered under the insurance provisions of the proposal. Emergency and ambulance services must be made available at all times. The corporation must schedule a periodic health examination for each enrollee.

The corporation would also be required to provide health education services designed to encourage healthful living and proper use of services, especially for low-income and medically indigent enrollees, with special assistance given to persons with language or educational handicaps.

A continuing personal health record (including medical histories and other information) would be maintained for each enrollee and be made available to the corporation's staff and affiliated providers (and, for emergency care, to unaffiliated providers). These records would be transferred when a member transfers to another corporation. The health records (which could be used for statistical purposes) could not be disclosed without the enrollee's permission, except when necessary for the administration of the program.

The corporation would be required to give emergency services to persons not enrolled with it and, if resources are available, could provide other services to nonenrollees.

Methods of Providing Services

The corporation could provide services directly through its own facilities and personnel, or through affiliated providers under contract with it. Affiliated providers could be institutions (hospitals, nursing facilities, or home health agencies) or practitioners (physicians, dentists, podiatrists, or optometrists). An affiliated provider could be a solo practitioner, partnership, clinic, or group practice plan and could be affiliated with more than one corporation (with one affiliation designated as the primary one).

Prescription drugs, medical appliances and equipment, and ambulance services could be furnished by nonaffiliated providers under approved arrangements. Specialized services could be also provided by arrangement with an unaffiliated provider.

Practitioners

Within its needs, the corporation must permit all practitioners to furnish services for it as staff members or affiliated providers. Also, consistent with its type of organization, the corporation must permit practitioners to choose their form of practice. The corporation would determine annually the scope of services that practitioners would be permitted to perform. It could not discriminate, in selecting practitioners or determining their services, on grounds unrelated to qualifications (but could prefer those located in the service area).

The bill states that medical judgments could be made only by physicians, that medical policies must be established with the advice of physicians, and that the participation of physicians in policy formulation and administration of the corporation should be encouraged. Physicians could not be disqualified, by State law or regulations, from serving on the governing board of a corporation.

Outpatient Centers

Through affiliated providers or other methods, outpatient centers would be established to furnish primary medical care and (to the extent possible) health maintenance services, home health care, medical social services, and well-baby and mental health care. The centers would make arrangements with other corporation facilities for additional diagnostic services and referral and transfer of patients.

Quality of Services

The corporation would be required to comply (for its own and affiliated services) with the general standards, described previously, concerning the quality and comprehensiveness of service, controls on utilization, and appraisal of the effectiveness of service. It must establish for this purpose, a system of peer review of medical services by a group of physicians (from the corporation and affiliated providers) and require similar review by a staff committee of affiliated hospitals and skilled nursing facilities. The State commission would review and approve the peer review system and evaluate the performance of the corporation.

The qualification of personnel must at least meet standards of professional organizations. The corporation must establish a program of continuing education for physicians, dentists, and nurses and, at its option, other professional personnel.

Charges and Reimbursement

Charges of corporations would be approved by the commission, based on the financial requirements needed to fulfill its responsibilities, in accordance with the general principles of reimbursement described above. Corporations would be responsible for justifying the budget and charges of affiliated providers.

Initially, the corporation could charge its enrollees either an annual capitation charge or separate charges for each service, but capitation must be made available to persons who wish to enroll on this basis, beginning 5 years after incorporation. The basic capitation amount would be the same for all enrollees, varied only by family size and composition, but a different rate could apply to federally contracted insurance.

The corporation would be responsible for payment for services given to its enrollees by out-of-area corporations, and emergency services provided by a nonaffiliated provider.

The methods of payment or compensation by the corporation to its staff and affiliated providers would be as mutually agreed. Arrangements between corporations and practitioners (which could be on a capitation, fee-for-service, or other basis) could not be restricted by State law or regulation.

Study of Capital Needs

The national health services advisory council, mentioned above, would make a special study of the capital needs of health care corporations and related organizations to examine methods of replacing traditional sources of capital financing with a national funding program. It would give consideration to establishing a national trust fund financed from health insurance premiums, a tax on these premiums, appropriated funds, or other public or private sources.

Other Activities

Manpower.--Corporations would coordinate personnel needs for itself and affiliated providers, conduct in-service training, and encourage the use of physicians' assistants and other paramedical personnel.

Records and reports.--Corporations would be responsible for keeping records and reports (for itself and affiliated providers) on financial matters, utilization of services and results of peer review. These records would be available for inspection by the commission for verification.

Evaluation and research.--Corporations would evaluate their own performance and conduct research on the delivery, quality, and cost of health services which would be made available to State and Federal Governments.

Grievances and Representation

The corporation would be required to establish procedures for handling grievances of enrollees or applicants for enrollment (and maintain records of the grievances for inspection by the State commission) and for settling disputes with affiliated and other providers.

The corporation would establish an advisory committee to represent its enrollees (and additional subcommittees or separate committees to represent groups of members with special interests) and provide other methods to permit its enrollees to express their views on its policies and operations.

Enforcement Powers

If the State commission determines that a corporation is not complying with laws or regulations, it could direct the corporation to correct the situation, take other action such as placing the corporation in receivership, or amend or repeal its approval. These orders or actions would be subject to hearing and court review. Also, other interested parties, such as other corporations and providers, could initiate an action to amend or revoke the approval of a corporation.

Federal Grants

The bill states the policy of the Federal Government to assist in the development of health care corporations, especially in poverty and rural areas, and appropriates, to the extent needed, funds for financial assistance to corporations as follows:

(1) grants for planning and development of corporations;

(2) grants for new or expanded outpatient care centers (also availableto nonproprietory providers affiliated with corporations);

(3) grants for medical equipment, data processing systems, and central-service equipment needed for initial operations; and

(4) contracts to pay the operating deficit of new or expanded corporations for a reasonable period.

In providing financial assistance, the Federal Government would consider the resources availability in various geographical areas and attempt to provide an equitable distribution of assistance. A maximum of 15 percent of the funds could be granted in any one State. For the first 5 years of the program, priority would be given to corporations operating on, converting to, or planning to convert to, a capitation basis and thereafter only to such corporations. Applications for financial assistance must be approved by the State commission.

In addition, the bill directs all Federal agencies providing financial assistance in the field of health care (such as construction of facilities) to use their funds to further the new program, and to give priority to health care corporations, especially those in poverty areas.

RAILSBACK BILL

The "National Health Insurance Partnership Act of 1971" was introduced by Representative Thomas F. Railsback of Illinois as H.R. 2618.

General Concept and Approach

The proposal would establish a two-part national health insurance plan that would cover almost all of the population under age 65. These include (1) a plan requiring employers to provide for employees and their families private health insurance with specified benefits and (2) a federally operated family health insurance plan for low-income families with children. The proposal includes provisions designed to encourage the formation and use of health maintenance organizations.

NATIONAL HEALTH INSURANCE STANDARDS ACT

The "National Health Insurance Standards Act" would require employers to make available to employees and their families a health care plan under private insurance providing specified benefits. Most benefits would be subject to cost sharing by the patient. The program would be administered by private insurance companies, under Federal supervision, and would be financed by employer-employee premium contributions.

Coverage of the Population

The Act would apply to all employers and employees except (1) employees of Federal, State, and local governments, (2) ministers and members of religious orders, and (3) aged persons under the Medicare program. All other employers must make coverage available to all full-time and part-time employees (who work at least 25 hours a week for 10 weeks, or a total of 350 hours in a 13-week period). The participation of the employee would be on a voluntary basis.

Coverage would be continued, at the option of the employee, for at least 90 days after employment terminated (if he was under the plan for at least 13 weeks) and could be continued further, but the employer would not be required to pay any premiums after the 90-day period.

Special group plans developed by insurance carriers would be available to small employers (those with less than 100 employees working 90 days or more during a 180-day period). Also, group plans would be developed for self-employed persons and other persons not under an employer plan. These special group plans would have to provide the same benefits and meet the same requirements as employer plans.

Employers with a collectively bargained health care plan in effect at the time the bill is enacted (and still in effect when the program began) would not have to establish a required plan until the contract expired.

Benefit Structure

The required employer plan would have to provide specified benefits and meet certain requirements. The plan could not exclude payment of benefits because of preexisting conditions for more than 6 months. (There could be no waiting period for maternity care.)

Hospital room and board is subject to a "2-day deductible" which refers to the reasonable cost for room and board for 2 days of care.

Most other benefits would be subject to an annual deductible of $100 per person, with a family maximum of three deductibles, plus 25 percent coinsurance (referred to below as "deductible and coinsurance"). This deductible is the total annual amount payable per person for all services subject to deductibles. After a person has received $5,000 of services in a year, all the cost sharing would be waived for him and his family for that year and the next 2 years.

There would be a lifetime maximum limit of $50,000 on total payments per person, with a $2,000 annual restoration. The covered benefits are shown as follows:

Institutional Services

Hospital inpatient care: 2-day deductible and 25 percent coinsurance for room and board per year. All other hospital services subject to deductible and coinsurance.

Hospital outpatient care: subject to deductible and coinsurance.

Personal Services

Physicians' services (nonpsychiatric): subject to deductible and coinsurance. Periodic examinations for children under age 5 (including immunizations and preventive care) with no cost sharing: six exams, birth to 6 months; six exams, age 7 months to 2 years; three exams, age 2 to 5 years. Annual eye examination for children up to age 12 subject to deductible and coinsurance.

Laboratory and X-ray: subject to deductible and coinsurance.

Outpatient physical therapy services: subject to deductible and coinsurance.

Other Services and Supplies

Medical supplies and appliances: subject to deductible and coinsurance (prosthetic devices excluded).

Ambulance services (only in emergencies): subject to deductible and coinsurance.

An employer plan could also make available benefits additional to those specified (or reduce or eliminate the cost sharing requirements). The employee would not be required to accept (or pay for) these additional benefits to be covered under the required plan. These additional benefits would not be subject to the requirements or conditions applicable to the required plan.

Administration

Employers would purchase basic health care plans from private insurance carriers who would collect the premiums and process the claims for benefits. They could also operate a plan on a self-insured or similar basis. Employees would have the option of enrolling with an approved health maintenance organization (these organizations are described later) and the employers would contract with these organizations for those employees who chose to enroll. Individuals and small employers could purchase coverage under special group plans.

The Department of Health, Education, and Welfare would be responsible for approving the employer plans and the special group plans. It would determine whether providers of services (including health maintenance organizations) meet standards and other requirements of the bill. It would also establish procedures for hearings in cases of denial of benefits by health maintenance organizations.

If the Department finds that an employer is not making a required plan available to his employees, the Federal Government could bring suit to compel the employer to do so. Employees may also bring suit.

Financing

Basic health care plans would be financed by premium contributions, with the employer paying at least 75 percent of the cost (for the first 2-1/2 years of the program, at least 65 percent). The provisions do not apply to the cost of any additional benefits included in the plan. The employer could, of course, pay the entire cost of the plan if he wishes to do so.

Employees who enroll in a health maintenance organization would pay no more than the regular premium for a required employer plan, but could

be required to pay an additional premium for any additional types of services provided (and for the actuarial value of the deductibles and coinsurance if these are reduced or eliminated by the organization).

Employers would receive subsidy payments from the Federal Government if their premium costs for employees covered under a required plan exceed 4 percent of the average wages paid to those employees. These payments would be equal to the amount of the excess for a maximum of 10 employees.

Employers would be able to take their unsubsidized premium contributions toward a required plan as a tax deduction.

FAMILY HEALTH INSURANCE PLAN

The "Family Health Insurance Plan" (FHIP) would establish a plan for low-income families with children not covered under a required employer plan. Benefits would generally be subject to cost sharing, which would vary with family income and size, but the lowest income group would pay nothing. The program would be administered by the Federal Government and would be financed by Federal general revenues, and by premium contributions (except for the lowest income group) graduated according to family income and size. The Medicaid program would be limited to the aged, blind, and disabled; persons age 65 and over would remain under Medicare.

Coverage of the Population

Low-income families with children could enroll in the family health insurance plan provided:

(1) their total annual family income does not exceed specified levels and total family resources do not exceed $1,500,

(2) the family member is not covered by Medicare or a required employer plan, and

(3) the family includes at least one dependent child under age 18 (or a student under age 22).

Families receiving payments under the proposed Family Assistance Plan (FAP) would automatically be covered.

Income Levels

Eligibility for coverage would depend on the family's annual income level as follows:

One-member family	$2,500
Family of 2	3,400
Family of 3	4,200
Family of 4	5,000
Family of 5	5,800
Family of 6	6,400
Family of 7 or more	7,000

Both earned and unearned income would be counted in determining family income, including payments under FAP, but food stamps and payments for foster children would not. In determining the $1,500 maximum on family resources, a family's home, household goods, and other personal effects would not be counted, nor would property essential to the family's self-support. Eligibility would be redetermined every 6 months. Coverage would end 9 months after notification that a person is no longer eligible (6 months if he becomes eligible for Medicare or is covered under a required employer plan).

Benefit Structure

The benefits provided under the family health insurance plan are shown in table 1. For the purpose of determining any deductibles and coinsurance amounts which may be applicable (as well as any premiums required, as discussed later) the eligible families are divided into five classes, depending on their income and size, according to the following tabulation:

Family size	Income class				
	1	2	3	4	5
1.....	0-$500	$501-$1,000	$1,001-$1,500	$1,501-$2,000	$2,001-$2,500
2.....	0-1,400	1,401-1,900	1,901- 2,400	2,401- 2,900	2,901- 3,400
3.....	0-2,200	2,201-2,700	2,701- 3,200	3,201- 3,700	3,701- 4,200
4.....	0-3,000	3,001-3,500	3,501- 4,000	4,001- 4,500	4,501- 5,000
5.....	0-3,800	3,801-4,300	4,301- 4,800	4,801- 5,300	5,301- 5,800
6.....	0-4,400	4,401-4,900	4,901- 5,400	5,401- 5,900	5,901- 6,400
7.....	0-5,000	5,001-5,500	5,501- 6,000	6,001- 6,500	6,501- 7,000

Class 1 families would not be subject to any cost sharing, Class 2 would pay only a hospital deductible, and Class 3 a deductible for various services but no coinsurance. Classes 4 and 5 would be subject to both deductibles and coinsurance. However, no cost sharing requirement would apply to maternity care, well-baby care, or family planning services.

TABLE 1.--RAILSBACK BILL: Benefit provisions under the Family Health Insurance Plan

Type of service	Benefits	Cost sharing for income class[1]				
		1	2	3	4	5
Institutional services						
Hospital:						
Inpatient	30 days per year.					
Room and board	See above	None	1-day deductible	1-day deductible	1-day deductible	2-day deductible.
Other services	See above	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Outpatient	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible 25% coinsurance.
Extended-care facility	3 days in an extended-care facility substituted for 1 day of hospital care.					
Room and board	See above	None	2-day deductible	2-day deductible	2-day deductible	4-day deductible.
Other services	See above	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 10% coinsurance.
Personal services						
Physicians' services:[2]						
In hospital, extended-care facility, or while receiving home health services.	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Outpatient, home or office[3]	8 visits per year	None	None	$50 deductible, 10% coinsurance.	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.

See footnotes at end of table.

TABLE 1.--RAILSBACK BILL: Benefit provisions under the Family Health Insurance Plan--Continued

Type of service	Benefits	Cost sharing for income class 1/				
		1	2	3	4	5
Personal services--Con.						
Physicians' services: 2/--Con.						
Emergency services	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Maternity care	No limit	None	None	None	None	None.
Family planning	No limit	None	None	None	None	None.
Periodic examinations 3/	Birth-6 mos., 6 exams.; 7 mos.-2 yrs., 6 exams.; 2-5 yrs., 3 exams.	None	None	None	None	None.
Eye examinations	Children under age 12, 1 exam. per year.	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Home health services	7 days of home health services substituted for 1 day of hospital care.	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Laboratory and X-ray	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Outpatient physical therapy services	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Other services and supplies						
Medical supplies and appliances	No limit	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Ambulance services	Emergencies only	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.
Prosthetic devices	Emergencies only	None	None	$50 deductible	$50 deductible, 10% coinsurance.	$100 deductible, 25% coinsurance.

1/ The $50 and $100 deductible is the total annual amount payable per family for all services subject to deductibles.

2/ Psychiatric services excluded.

3/ Includes preventive care, immunizations, and checkups.

Administration

The Department of Health, Education, and Welfare would be responsible for general administration of the program including the determination of eligibility and the regulations, standards, and hearings procedures for the program. As under the Medicare program, private insurance carriers under agreement with the Department would act as fiscal agents for payment of claims for services, and State agencies would determine whether providers of services qualify for participation in the program.

At their option, States could establish supplemental benefit plans to provide benefits additional to those under the national program. The Department would administer these plans on behalf of the State, if the State wishes. In this case, the State would pay the cost of its benefits and the Federal Government would pay the administrative cost.

Eligible families under the program would have the option of enrolling in a health maintenance organization.

Financing

The Family Health Insurance Plan would be financed by premium payments from those enrolled families required to pay premiums, and from Federal general revenues.

The amount of the annual premium payment would depend on the class of the family, as described above. The lowest income class (Class 1) would pay no premiums. For others, the premium is shown as follows:

Income class 2	$25
Income class 3	50
Income class 4	75
Income class 5	100

Premium payments could be deducted from the cash benefits payable under the FAP program, the social security program (OASDI), or a State program supplemental to FAP.

Persons who enroll with a health maintenance organization would be required to pay the same premium (if any) for the specified benefits. If the organization provides additional services, or reduces or eliminates the deductible and coinsurance, it may charge an additional reasonable premium.

PROVISIONS AFFECTING ALL PLANS

Relationship to Other Government Programs

The Medicare program would continue to operate; persons age 65 and over entitled to Medicare benefits would not be eligible under the employer or FHIP plans. The Medicaid program would be limited to the aged, blind, disabled, and children in foster care. Most other government programs would not be affected.

Standards for Providers of Services

Providers of service would have to meet the same standards as under the Medicare program (see page 225).

Professional Standards Review Organizations

The bill would apply the provisions of the Professional Standards Review Organizations (PSRO) for Medicare and Medicaid to the required employer plans and FHIP program. The PSRO programs establish boards of physicians at the local level to review the quality and appropriateness of services provided.

Reimbursement of Providers of Services

Institutions

Payment to hospitals, extended-care facilities, and home health agencies would be based on the "reasonable cost" of services, as under the Medicare law.

Physicians and Other Suppliers

Payments to physicians, dentists, and other health care personnel and suppliers would be based on the "reasonable charges" for their services, as under the Medicare law. However, under the FHIP program, physicians and others would have to accept the reasonable charge as their full payment (and could not make additional charges to the patient).

Health Maintenance Organizations

Under the employer plan, health maintenance organizations (HMO's) would be paid on a per capita basis for persons enrolled (as negotiated between the employer and the HMO). Under the FHIP program, HMO's would be paid a prospective per capita rate equal to 95 percent of the estimated amount needed if the services were furnished by other providers in the area.

The HMO could make various arrangements to reimburse its physicians. The physicians could be employees or partners of the HMO, or the organization could make arrangements with physician groups which, in turn, would pay the individual physicians on a fee-for-service or other basis.

Special provisions relating to the rate of retention (the organization's revenue minus its expenses) require that the retention applicable to the FHIP enrollees must be slightly less (90 percent) than the retention rate applicable to other groups enrolled in the organization. Any excess amount must be used to provide additional benefits or reduce premium rates for FHIP enrollees.

Delivery and Resources

Health Maintenance Organizations

Provision is made for health maintenance organizations--public or private organizations which provide health services to enrollees on a per capita prepayment basis--to participate in the program. As described previously, persons under both the employer and FHIP plans would have the option of enrolling with an HMO. The organization would have to meet the following requirements:

(1) provide all of the services and benefits covered under the program, either directly or under arrangement with others;

(2) assure that health services are furnished promptly and appropriately;

(3) utilize institutions, facilities, and health care personnel that meet the standards of the Medicare program, and any additional quality standards established by regulation;

(4) demonstrate it is financially responsible and capable of providing comprehensive health care services efficiently and economically;

(5) have not less than 10,000 enrolled members (this requirement may be delayed up to 3 years if the HMO is making progress to reach this number); it also may be waived (for an indefinite period) if, because of geographical location or other circumstances beyond its control, the HMO is unable to comply;

(6) if participating in the FHIP program, at least half of its members have to be persons not covered under FHIP or Medicaid;

(7) have an open enrollment period at least every year; and

(8) permit the Department, or its designee, to evaluate the services and records of the HMO.

Any State law or regulation which prevents an HMO from carrying out its agreement with the Department under FHIP would be inapplicable, as would any State law or regulation that limits a physician affiliated with an HMO from delegating certain duties to appropriate personnel.

Health Planning

The bill would impose the same provisions imposed under Medicare and Medicaid, limiting reimbursement to providers of services in connection with their capital expenditures, if these expenditures are not in conformity with the comprehensive plan of a State or areawide planning agency. These provisions were contained in recent legislation, P.L. 92-603 (H.R. 1).

BURLESON-MCINTYRE BILL

The "National Health Care Act of 1973" was introduced by Representative Omar Burleson of Texas as H.R. 5200 and Senator Thomas J. McIntyre of New Hampshire as S. 1100. It is supported by the Health Insurance Association of America.

General Concept and Approach

The bill provides three voluntary health insurance plans to make coverage available to the entire population. The plans include: (1) an employee-employer plan, (2) an individual plan, and (3) a plan for the poor and uninsurable. All plans would provide after a phasing-in period a broad range of medical care services, with benefits generally subject to cost sharing by the patient. Also, all plans would be administered through private insurance carriers and supervised by the State and Federal Governments. The employee-employer plan and the individual health plan would be financed by premium contributions, and contributors would receive tax advantages. The plan for the poor would be financed mainly by Federal and State general revenues. The bill includes provisions designed to increase the supply of health manpower, the development of ambulatory care centers, the expansion of health planning, and the improvement of cost controls.

EMPLOYEE HEALTH CARE PLAN

The employee health care plan would, through use of the tax mechanism, encourage employers to provide qualified health insurance plans with specified benefits for employees and their dependents. Private insurance carriers would collect the premiums and process the claims for benefits. The premiums would be paid by the employer and employees. The plan would be supervised by State insurance departments. The Federal Government would determine the status of a plan under the tax laws.

Coverage of the Population

Persons working for employers who voluntarily establish a qualified plan would be covered. Such a plan must cover all full-time and part-time employees (who work at least 20 hours a week for at least 26 weeks during the year) and their dependents. New employees must be covered within 3 months. Coverage under the plan would continue, as follows:

(1) 2 months after termination of employment;

(2) 12 months during a layoff or labor dispute, if the employee pays the employee contribution for the first month and the total employee-employer contributions for later months;

(3) 30 months if absent because of illness or disability;

(4) 2 months of coverage for the surviving family in case of the employee's death.

Benefit Structure

Under present law, an employer may take the full cost of his premium contributions for health insurance as a business deduction for tax purposes. Under the bill unless an employer has a qualified plan, the premium cost would not be an allowable deduction, beginning in the third year after enactment of the bill (in the first year, 50 percent would be deductible and in the second, 25 percent). If a medical care plan established through a collectively bargained agreement was in effect when the program started, this provision would not apply until the expiration of the agreement, but not later than 3 years after the program started.

In addition, under present income tax law, employees and other persons who itemize their deductions on their individual income tax returns may deduct one-half of the premiums for private health insurance up to a maximum of $150, with the remainder deductible only to the extent that total medical expenses exceed 3 percent of adjusted gross income. Under the proposal, the employees who itemize may take their entire contributions toward a qualified plan as a medical expense deduction.

The required standard health care benefits are shown in table 1. These benefits would be phased in, with priority I benefits becoming available at the start of the program; priority II, 5 years later; and priority III, 5 years thereafter. Under a "catastrophic expense" provision applicable during the phasing-in period, a person who incurs $5,000 in covered medical expenses would automatically become entitled to priority III benefits (subject to a lifetime maximum of $250,000). If the health council (established under the bill) advises that facilities and services are not available, the President may defer the phasing in of benefits.

In lieu of the specific dollar copayments applicable to various services, coinsurance up to 20 percent may be required (except where a higher coinsurance percentage is specified in table 1). Also, in addition to the other requirements, an annual deductible of up to $100 per family may be imposed, but the deductible for a service cannot be larger if given on an ambulatory basis than in an institution. The total

TABLE 1.--BURLESON BILL: Standard health care benefits

Benefit	Cost sharing	Benefits and effective date		
		Priority I	Priority II	Priority III
		Private plans 1/75	State plans 7/74 Private plans 1/80	State plans 7/79 Private plans 1/85
Institutional Services				
Hospital inpatient 1/	$5 per day	30 days per illness	120 days per illness	300 days per illness.
Extended care: Inpatient 1/	$2.50 per day	60 days per illness	120 days per illness	180 days per illness.
Personal Services				
Physicians' services:2/				
In hospital	$2 per day	30 days	120 days	300 days.
	$5 per day	After 30 days	After 120 days	After 300 days.
In skilled nursing facility	$2 per day	60 days	120 days	180 days.
	$5 per day	After 60 days	After 120 days	After 180 days.
Office visits:3/				
Diagnosis or treatment	$2 per visit (mental--50 percent after 6th visit).	3 visits per year	6 visits per year	No limit.
Surgery and radiation therapy	$2 per visit	No limit	No limit	No limit.
Laboratory and X-ray	None	No limit	No limit	No limit.
Family planning	None	No benefit	No limit	No limit.
Periodic exams:				
Under age 5	None	6 exams (birth to 6 months)	6 exams (age 7 months to 2 years).	3 exams (age 2 to 5 years).
Age 5 to 39	None	No benefit	No benefit	1 exam. every 5 years.
Age 40 and over	None	No benefit	No benefit	1 exam. every 2 years.
Eye examinations:				
Under age 19	None	No benefit	No benefit	1 exam. per year.
Age 19 and over	50 percent	No benefit	No benefit	1 exam. every 3 years.
Home visits	$5 per visit (mental 50 percent).	No benefit	No benefit	No limit/

See footnotes at end of table.

TABLE 1.--BURLESON BILL: Standard health care benefits--Continued

Benefit	Cost sharing	Benefits and effective date		
		Priority I	Priority II	Priority III
		Private plans 1/75	State plans 7/74 Private plans 1/80	State plans 7/79 Private plans 1/85
Personal Services--Continued				
Dentists' services:				
Examination:				
Under age 19	None	No benefit	1 exam. per year	1 exam. per year.
Age 19 and over	None	No benefit	No benefit	1 exam. per year.
Fillings, extractions, and dentures:				
Under age 19	20 percent	No benefit	No limit	No limit.
Age 19 and over	20 percent	No benefit	No benefit	No limit.
Other (excludes orthodontia)	50 percent	No benefit	No benefit	No limit.
Home health services	$2.50 per day	90 days	180 days	270 days.
Independent laboratory	None	No limit	No limit	No limit.
Optometrist, eye examination	Same as eye examinations shown under physicians services above.			
Physical therapy	20 percent	No benefit	No limit	No limit.
Speech therapy	20 percent	No benefit	No benefit	No limit.
Other Services and Supplies				
Prescription drugs	$1 per prescription	No benefit	No limit	No limit.
Prescription contraceptives	$1 per prescription	No benefit	No limit	No limit.
Prostheses 4/	20 percent	No benefit	No limit	No limit.
Eyeglasses:				
Under age 19	None	No benefit	No benefit	1 pair per year.
Age 19 and over	50 percent	No benefit	No benefit	1 pair in 3 years.
Pregnancy: Physicians' services, hospital, skilled nursing facility, independent laboratory, home health services.5/	20 percent	From beginning of pregnancy to 30 days after birth.		
Catastrophic expense benefits	For persons who incur $5,000 in medical expenses, priority III benefits always applicable.			

1/ 2 (or more) separate stays considered a single period of illness unless separated by 60 days or more.

2/ Includes services of Christian Scientist practitioners, and podiatrists in certain capacities (routine foot care is excluded).

3/ Includes services rendered in hospital outpatient department.

4/ Hearing aids excluded.

5/ Priority II benefits always apply to these services.

payment for a family for all cost sharing (deductibles, copayments, and coinsurance) is limited to $1,000 in a year.

The plan may provide benefits in addition to those required under a qualified policy.

Administration

Employers would purchase qualified policies from private insurance companies which would collect the premiums and process the claims for benefits. The policies must be approved by the State insurance department as satisfying the requirements for a qualified policy. The Department of the Treasury may accept the approval of the State insurance department in determining the tax status of the premiums for income tax purposes.

Under provisions designed to protect against insolvency, carriers underwriting insurance under the program are required to have a combined capital and surplus of $1.5 million. As an alternative, the requirement can be met by securing a performance bond or contracting with another carrier to assure continued coverage in event of failure.

In addition, companies are required to maintain a "NHI contingency reserve" equal to its current liabilities (for claims and related expenses) plus 12-1/2 percent of the amount of claims paid in the previous year. The companies must file annually with the State insurance commission a statement of its NHI reserves and its financial condition. A company not meeting the requirements would be considered "impaired." Such a company must meet special conditions and submit a plan to the insurance commission for meeting its obligations and, if this plan is disapproved, an additional plan for review by a special committee of representatives of the insurance industry. This committee may decide that an assessment on other participating carriers is necessary to raise the necessary funds and, if so, the assessment would be made on a State basis, charged separately to either commercial insurers or Blue Cross-Blue Shield insurers (depending on which type of insurer has failed).

Financing

The premiums for an employee plan would be paid by employers to the insurance carrier. As arranged between employers and employees, the employees may be required, without limitation on the amount, to contribute to the premiums, except that the amount of the employee's contribution would be limited to 10 percent of his monthly wages over the following amounts:

Individual	$167
Family, with one dependent	250
Family, with two or more dependents	333

For example, the maximum contribution for an employee with one dependent earning $300 monthly would be $5 (10 percent of $50).

INDIVIDUAL HEALTH CARE PLAN

The individual health care plan would provide income tax incentives to encourage the purchase of individual (nongroup) qualified insurance providing specified health insurance benefits. The premiums would be paid by the policyholder. The State and Federal Governments would have supervisory responsibilities similar to those under the employee plan.

Coverage of the Population

All persons would be eligible to voluntarily purchase a qualified individual health care policy for themselves and their families. This plan would make qualified insurance available to self-employed persons and others not eligible under the employee or State plans.

Benefit Structure

Persons purchasing a qualified individual policy may, if they itemize their deductions on their personal income tax return, take the entire premium cost as a medical expense deduction (as explained previously for employee contributions toward a plan).

The medical care benefits of an individual policy are identical to those under the employee plan and would be phased in at the same time (table 1). As in the employee plan, coinsurance up to 20 percent may be substituted for the copayments applicable to the various benefits and an additional deductible may be imposed (which must not be larger for ambulatory than for institutional care). For an individual plan, no limit is placed on the amount of this deductible or on the total amount of cost sharing that could be required in a year.

The policy could include benefits in addition to those required under a qualified policy.

The insurance policy must be renewable, but the insurance carrier may adjust the premium rates for a class of policies according to the experience for that class. Coverage under the policy ends when the policyholder becomes covered under another type of qualified policy or becomes eligible for Medicare benefits.

Administration

The individual would purchase the insurance from a private insurance carrier. Policies must be approved by the State insurance department as being qualified and the Treasury Department may accept this approval in determining the tax deductibility of the premium cost. The provisions regarding insolvency also apply to individual policies.

Financing

The policyholder would pay the entire premium cost to the insurance carrier.

STATE HEALTH CARE PLAN

The State health care plan is designed to provide the standard benefits for the needy, the uninsurable, and certain others. It would be administered by a private insurance carrier (or group of carriers) in each State and financed by premium payments from covered persons and contributions from State and Federal general revenues.

Coverage of the Population

Coverage under the State health care plan would be available to various groups of persons, if not eligible under a qualified employee plan, as indicated below.

(1) Needy persons.--Individuals and families could voluntarily enroll in the State plan if their adjusted gross income for income tax purposes was less than the following annual amounts:

Individual	$4,000
Family of two	6,000
Family of three or more	8,000

Eligibility could also be met on a monthly basis, if income for each of the last 2 months was below the following amounts:

Individual	$83
Family of two	125
Family of three or more	166

Public assistance recipients would be eligible for coverage under the State plan without regard to their actual income.

(2) Uninsurable persons.--Coverage under the State plan would be available on a voluntary basis to persons who cannot obtain a qualified individual policy because they are uninsurable (usually because of poor health). The person is considered uninsurable if he applies to three insurance carriers who either refuse to issue a policy or offer one at a premium cost greater than twice that of the State plan.

(3) Special groups.--Groups of persons who are receiving substantially all their medical care under a Federal or State program may be enrolled as a group under the plan. (These could include, for example, dependents of servicemen and inmates of an institution.) Under this provision (which does not apply to public assistance recipients as a group) the Federal or State Government would pay the entire premium for the group.

Enrollment

Families and individuals may voluntarily enroll by filing application with an administering carrier during an open enrollment period each year. Those becoming eligible later may apply within 30 days of their eligibility. Public assistance cash recipients must be enrolled by the State public assistance agency. Coverage for all enrollees continues for the balance of the policy year regardless of change in the eligibility status of an individual family member.

Benefit Structure

The proposed law does not directly require a State to establish a health care plan. It permits payment of benefits under a State plan beginning July 1974 and requires, in this case, that priority II benefits be paid initially and priority III benefits beginning July 1979. (As indicated on page 93, the Medicaid program would be limited to noncovered benefits beginning July 1975.) A delay by the President in the phase-in of benefits would also apply to these benefits, as described earlier.

The same cost-sharing requirements applicable to the other plans apply to the State plan, but special provisions limit the total amont of cost sharing to $50 in a year for needy persons having adjusted gross income less than the specified amounts shown as follows:

Individuals	$2,000
Family of two	3,000
Family of three or more	4,000

For those with higher income, the maximum amount of cost sharing would be limited to 10 percent of their income over these specified amounts (but not less than $50). For example, a family of three or more with income of $5,000 would pay a maximum of $100 (10 percent of $1,000).

The State plan could provide benefits in addition to the standard benefits, but the Federal Government would not share in the cost of additional benefits.

Administration

The State plan would be administered by an insurance carrier under an agreement between a State and the carrier, with the approval of the Department of Health, Education, and Welfare. The administering carrier could be a commercial insurance company, a service benefit organization, or any of several other types. The administering carrier would determine eligibility for enrollment in the plan, collect the premiums and government contributions, process claims for benefits, pay providers of services, and administer the State plan insurance pool. Individuals and families enrolled in the plan would be issued health insurance policies.

The operation of the plan would be under the supervision of the State insurance department, and payment to providers would need to meet the standards of the State cost commission.

At the Federal level, the Department of Health, Education, and Welfare would issue regulations for operation of the plan. These regulations would need to be issued in final form at least 9 months before the policy year to which they apply.

As a condition of receiving Federal Government contributions for the State plan, the State must agree that it will not impose a premium tax or similar tax on the State plan, and that it will levy taxes on health insurance business in the State equally on all carriers.1/

Financing

The State plan would be financed by premium payments of enrolled families, graduated according to income, and by contributions from State and Federal general revenues.

The amount of the full premium would be determined by the administering carrier. The full premium would be an amount actuarially sufficient to meet the total cost of the program. The premium amount would be based on the previous year's experience (adjusted for estimated increase in costs) and would include an allowance for the benefit cost and for costs

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1/ In many States, Blue Cross and Blue Shield are exempt from premium taxes and other taxes applicable to other carriers.

of administration, and a risk charge equal to 1 percent of the benefit cost. It would also include an allowance for repayment in full of State insurance pool losses to reinsuring carriers for past years.

The premium rates determined by the carrier would be reviewed by the Chief Actuary of the Social Security Administration, who could recommend a reduction to the Department of Health, Education, and Welfare. If so, at the request of the State, a hearing would be held before a board of three actuaries appointed by the Department (including one with the concurrence of the State and one with the concurrence of the carrier). If the hearing board determined the premium rates were too high, the Federal contributions to the State plan could be reduced.

Contributions of Policyholders

Policyholders would pay a premium based on their adjusted gross income. Needy persons under the State plan would not pay any premium if their income for the year was below the amounts specified below:

Individuals	$2,000
Family of two	3,000
Family of three or more	4,000

Those with income above the specified limit would pay 10 percent of the amount above this limit. For example, a family of three or more with an income of $5,000 would pay $100 (10 percent of $1,000) toward the premium.

For those eligible on the basis of the monthly income test, the monthly premium would be:

Individuals	$16.67
Family of two	25.00
Family of three or more	33.33

Uninsurable persons would pay the full actuarial premium rate. The State and Federal Governments would pay the rest of the premiums of the State plan--in effect, the premiums for those who do not contribute and the balance of the premiums for those who pay part. Thus, the plan would receive a full premium for all enrolled persons. The Federal share of the total government contribution would be 70 to 90 percent, depending on the per capita income of the State.

State Insurance Pool

The premiums and other income of the plan would be deposited in a State insurance pool from which all benefits and expenses of the plan would be paid. The pool would be reinsured by all health insurance carriers licensed in the State and if the pool suffered a loss in the year, the

loss would be borne by the carriers according to an agreed formula, up to a maximum of 3 percent of premiums. (As indicated previously, carriers would later be reimbursed for any losses they have borne.) Any additional loss would be absorbed by the State and Federal Governments (according to the sharing formula). If the pool showed a gain, it would be retained by the pool and used to reduce the State's future premium contributions to the pool.

Provisions For the Aged

Persons age 65 and over could be covered under the State plan under special provisions applicable to that group. Aged persons must be enrolled in the voluntary supplementary medical insurance plan (Part B) of Medicare to be eligible for State plan coverage. If their income is above the specified limits, so that they would be required to pay premiums, the amount of the premium would be reduced by the amount of the Part B premium. If their income is below the specified limits, the State would pay the Part B premium on their behalf from State general revenues. The Medicare program would continue to operate and would have initial liability in paying for services.

PROVISIONS AFFECTING ALL PLANS

Relationship to Other Government Programs

As indicated, the Medicare program would continue to operate. The proposal specifies that, effective July 1975, the Medicaid program would not pay for medical services provided under a State plan, nor for cost sharing required by the plan. Most other government programs would not be affected.

Standards for Providers of Services

Institutions

Health care institutions (hospitals, skilled nursing facilities, and home health agencies) would have to meet the same standards as under the Medicare program (see page 225).

Health Maintenance Organizations

Health maintenance organizations which furnish health care services to enrollees on a per capita prepayment basis would be required to meet quality standards established by regulation.

Physicians and Dentists

Physicians and dentists would have to be legally authorized to render services by the State in which they provide their services.

Institutions

Payments to health care institutions (hospitals, skilled nursing facilities, and home health agencies) would be based on prospectively approved rates for different categories of institutions. Institutions would be required to prepare a budget, based on a standard accounting system, and recommend a schedule of charges which would apply to all patients. Annually, a State health care institutions cost commission, following its review of the budgets and proposed charges, would approve or disapprove the rates.

The charges for services would need to be reasonably related to the cost of efficient production of the services. In its review, the commission would take into account economic factors in the area, costs of comparable institutions providing comparable services, capital requirements, and the need for incentives to improve service and institute economies.

The State commission could approve the use of a single charge for a group of services commonly rendered to a class of patients, or a single all-inclusive daily charge for all inpatient services. The level of rates approved for different categories of institutions would be reviewed by the Department of Health, Education, and Welfare. If the Department determined the rates for a given category were unjustifiably high in relation to other States, Federal funds for Medicaid and for the State plan under this proposal would be reduced.

Health maintenance organizations would be paid on the basis of per capita charges, which could not exceed the regular premiums for the plan.

Physicians and Dentists

Payment to physicians, dentists, and other health-care personnel would be based on reasonable charges, taking into account the customary charge of the practitioner and the prevailing charge in his locality. Payment could not exceed the prevailing charge (which would be set at the 75th percentile of the distribution of actual charges made for similar services during the previous year).

Other Government Programs

Payments to providers for reasonable costs or reasonable charges under the Medicare, Medicaid, and maternal and child health programs could not exceed the reasonable cost or charge as determined under the proposal.

Health Maintenance Organizations

Provision is made for health maintenance organizations--organizations which provide health care services to enrollees on a per capita prepayment basis--to participate in the program. A health maintenance organization would have to provide--either directly or under arrangements--all of the standard health care benefits.

The State plan and employee plans must make health maintenance organizations available as an option for those enrolled in the plans, assuming an HMO was available in the area. For an individual plan, the policyholder could select a health maintenance organization.

Comprehensive Ambulatory Health Care Centers

The bill includes provisions designed to encourage development of comprehensive ambulatory health care centers. These are facilities (located in or apart from a hospital) that are organized to provide a broad range of ambulatory health services and that have the following services and facilities:

(1) Medical, surgical, and preventive care services, including health education.

(2) Arrangements for treatment at a general hospital and other institutions when inpatient care is needed.

(3) Operating and recovery rooms.

(4) Laboratory and X-ray facilities.

(5) Unified medical records.

(6) Peer review programs.

(7) A plan to use allied health personnel.

Grants, loans, and loan guarantees are authorized for the construction or modernization of centers in areas designated by the State comprehensive health plan, and to pay their operating deficits for the first 3 years of operation. Priority would be given to putting facilities in densely populated areas where none exist. Special project grants are authorized for training personnel to staff the centers.

Health Planning

(1) A council of health policy advisors to the President would be created for the purpose of (a) recommending improvements in the organization, financing, delivery, and quality of health care; (b) recommending guidelines for the allocation of funds for health care; and (c) appraising Federal health programs and recommending procedures for interagency coordination.

(2) The bill increases appropriations under existing Federal programs for grants for comprehensive health planning at the State and local level and expands the scope of planning agency responsibilities.

(3) Comprehensive health planning agencies would have to certify as to the need for the health project before grants, loans, and other financial aid in excess of $100,000 could be made under Federal programs.

Health Manpower

(1) The bill expands the student loan provisions of the Public Health Service Act for training in the health professions (physicians, dentists, pharmacists, etc.) by increasing to $5,000 the dollar limit for an academic year for tuition and fees, room and board, supplies, books, and other related costs.

(2) Similar loans up to $3,500 are provided for the training of nurses.

(3) Similar loans are provided for training in the allied health professions, without any dollar limit on the amount of the loan. If the person after graduating is employed full-time in these occupations, 20 percent of the loan may be cancelled each year (up to 50 percent of the total loan). If employed in a shortage area, one-third of the loan may be cancelled each year (up to 100 percent of the total loan). The bill also provides for scholarship grants to students training in allied health professions, covering the full cost of tuition and other student expenses.

(4) Grants are provided to trained health professionals, allied health professionals and nurses for serving in areas of critical need for at least 2 years. These individuals would receive guaranteed income payments equal to 110 percent of the annual median income for persons of comparable education and training, or 110 percent of their own earnings in the previous year, whichever is greater.

(5) Special project grants are provided to schools of medicine, training centers for allied health professionals, and other educational institutions to develop and evaluate curriculums to train and coordinate teams of personnel to staff ambulatory health care centers.

FUQUA BILL

The "National Health Care Act of 1973" was introduced by Representative Don Fuqua of Florida as H.R. 559. It is identical to H.R. 4349 introduced by Representative Omar Burleson in the 92d Congress. Representative Burleson has introduced a revised bill, H.R. 5200, supported by the Health Association of America, discussed previously.

The major revisions in the current Burleson bill (which distinguishes it from the old Burleson and the current Fuqua bills) are as follows:

EMPLOYEE HEALTH CARE PLAN

(1) The provisions for continuation of family health insurance coverage of employees in event of termination of employment, absence because of illness or disability, or death of the employee, are changed.

(2) The provision concerning the disallowance of medical expense premiums as a business expense deduction for tax purposes, where a business has a nonqualified health plan, has been revised to eventually eliminate the deduction.

(3) The types and amounts of hospital and medical benefits are phased in over a longer period than the earlier bill and a catastrophic expense benefit, which is applicable temporarily during the phasing-in period, has been added.

(4) Certain services of Christian Science practitioners and podiatrists are covered.

(5) The States are required to monitor the financial soundness of insurance carriers, and to assess all participating carriers in the State to protect against the possible insolvency of a carrier.

(6) The amount of the employee contribution toward the health insurance premium, previously unlimited, is limited to 10 percent of his wages over specified amounts.

(7) The annual income limits for eligibility for the State health plan for the medically needy have been raised. Also, eligibility may now be met according to a monthly income test.

(8) The rate of cost sharing (deductibles and coinsurance and copayments) and the maximum cost sharing amount, for the medically needy group, is raised.

(9) A monthly premium is established for families eligible for benefits based on the monthly income test (see item 7).

PROVISIONS AFFECTING ALL PLANS

(10) The annual amount of the loan available to a student for training in the health professions and in nursing is limited to specified maximums. Previously, no limit was indicated.

JAVITS BILL

The "National Health Insurance and Health Services Improvement Act of 1973" was introduced by Senator Jacob K. Javits of New York as S. 915.

General Concept and Approach

The bill would establish a national health insurance program based on an expansion of the Medicare program to the general population. The proposal would provide a broad range of medical benefits to all U.S. residents, following a "phasing-in" period. Benefits would generally be subject to cost sharing by the patient. The program would be financed by payroll taxes and general revenue contributions, and be administered by the Federal Government. Options would be available to obtain approved alternative coverage under private insurance outside the Government program. The bill includes provisions to encourage the formation of comprehensive health service systems.

Coverage of the Population

The first groups to become eligible at the start of the program would be U.S. citizens aged 65 and over (and aliens aged 65 and over residing in the U.S. for at least 5 years, or eligible for social security benefits). Persons of any age entitled to social security disability benefits would also be covered.

In the second stage, 2 years later, coverage would be extended to all persons not previously covered who are resident U.S. citizens or aliens admitted for permanent residence. Persons would be eligible for benefits without regard to whether they have made contributions to the program.

Benefit Structure

In its final form, the proposal would provide the benefits of the present Medicare program and three new services: annual physical checkups, dental care for children under 8 years of age, and prescription drugs for chronic illness. The benefits of the proposal are as follows: Several types of services are subject to the present Part B provision of the Medicare law which requires a $60-annual deductible, per person, and a 20-percent coinsurance payment:

Institutional services

Hospital inpatient care: 90 days of inpatient hospital services per benefit period with a "lifetime reserve" of 60 additional days. (A 190-day lifetime limit applies to stays in psychiatric hospitals.) The patient pays the Medicare deductible in each benefit period and, in addition, a copayment for each day after the 60th. There would also be a copayment for each day of the lifetime reserve.1/

Hospital outpatient care: subject to Part B cost sharing.

Skilled nursing facility services: following a hospital stay, for 100 days per benefit period with copayment for days following the 20th.2/

Personal services

Physicians' services: subject to Part B cost sharing. Psychiatric physicians' services limited to a maximum annual payment of $250 for ambulatory care.

Physical checkups: annually, including eye and ear examinations and diagnostic tests, subject to a 20-percent coinsurance payment (with no deductible). The amount of payment would be the smaller of $75 or the amount charged by the most efficient provider in the locality. The benefit would begin 3 years after the start of the program.

Dentists' services: routine dental care for children under age 8. Orthodontia is excluded. Payment is subject to 20-percent coinsurance (with no deductible). Coverage would begin 3 years after the start of the program.

Home health services: 100 post-hospital home health visits per benefit period, without deductible or coinsurance under Part A and 100 visits under Part B, with no coinsurance.

1/ The Medicare deductible in 1974 was $84. The coinsurance rates, which are related to the deductible, are one-quarter of the deductible ($21) after the 60th day, one-half the deductible ($42) for the lifetime reserve, and one-eighth ($10.50) for skilled nursing facilities. The amount of the deductible is changed each January if the average per diem rate for hospital care rises.

2/ *Ibid.*

Laboratory and X-ray: subject to Part B cost sharing.

Outpatient physical therapy services: subject to Part B cost sharing.

Other Services and Supplies

Medical supplies and appliances, and ambulance service: subject to Part B cost sharing.

Prescription drugs: maintenance drugs for the treatment of chronic diabetes, cardiovascular diseases, and kidney and respiratory conditions. There would be a $1 charge per prescription and this amount would be adjusted in future years according to changes in the per capita cost for drugs. The benefit would begin 1 year after the start of the program.

Administration

As under the Medicare program, the Department of Health, Education, and Welfare would be responsible for general administration of the program, including the regulations and standards for the program. Private insurance carriers under agreement with the Department would act as fiscal intermediaries for payment of claims for services, under standards established by the Department. If the Department determined that the fiscal intermediary in an area has not performed its duties adequately, a federally chartered quasi-governmental corporation could be established to replace the intermediary.

State agencies would continue to determine whether providers of services meet the conditions for participation in the program. The Health Insurance Benefits Advisory Council would be retained to advise the Department on policy and administrative matters.

The bill also authorizes the Department to make agreements with States to administer the entire program on behalf of the Department.

Optional Alternatives to the Government Program

The bill automatically covers all eligible persons under the Government program unless they are covered under an approved alternate private insurance plan.

Employer-Employee Health Plan Option

An employer by contract with the Department could establish for his employees a qualified plan which meets the following requirements:

(1) health benefits are provided through an insurance carrier or a union-management health and welfare plan,

(2) all employees and their dependents are covered,

(3) the employer pays at least 75 percent of the cost,

(4) the benefits are superior to those under the Government program,

(5) hearings are available for dissatisfied claimants, and

(6) methods of payment of physicians are the same as under the Government program.

Employers and employees covered under an approved plan would be exempt from the regular insurance tax.

Private Health Insurance Option

Private carriers by contract with the Department could offer alternative health insurance policies, which meet the following conditions:

(1) the insurance is offered to all living in a specified area,

(2) the selection of policyholders meet regulations concerning selection of risks,

(3) benefits are equal to those furnished under the Government program and the cost is no greater,

(4) premiums for additional (noncovered) benefits are reasonable, and

(5) hearings are available for dissatisfied claimants.

The bill does not specifically exempt persons under an approved private insurance plan from payment of the health insurance tax.

The bill provides for coverage under a comprehensive health service system for persons under the Government program who choose to do so. An approved employer-employee plan or an individual health plan may offer this option.

Relationship to Other Government Programs

The bill would, in effect, absorb the Medicare program and include its beneficiaries in the Government-administered program. Since the Javits proposal is based on the Medicare law, its relationship to other Government programs would be essentially the same as Medicare. In general, Medicare will not cover services paid by a Government entity, but exceptions can be made in certain cases. Arrangements have been made for Medicare to reimburse OEO and HEW community health centers for the cost of covered medical services and to pay providers for services rendered to persons eligible under the CHAMPUS program.

For State and local health programs, Government hospitals have been approved for payment and Medicare will pay for services which otherwise would be financed by vocational rehabilitation agencies.

In the case of Medicaid and the Maternal and Child Health Program, both of which are part of the social security legislation, the law specifically provides that Medicare would have initial liability in paying for services.

Financing

The bill would combine the Medicare supplementary medical insurance program (Part B) with the hospital insurance program (Part A), and thus eliminate the premium payments for supplementary insurance.

The Government program would be financed by a health insurance tax on wages and self-employment income, with additional contributions from Federal general revenues.3/ The tax rates are graduated over a 5-year period to meet the increasing financial needs as new benefits and additional persons are phased into the program. Contribution rates for employers and employees (and for self-employed persons) would be 0.7 percent of taxable wages for the first year of the program and would be increased each year, ultimately reaching a rate of 3.3 percent after 5 years.

3/ As noted previously, employers and employees covered under an approved employer-employee health plan would be exempt from the special health insurance tax.

The health insurance tax would apply to the first $15,000 of earnings of employees and the self-employed, and to the employer's total payroll. The contribution from Federal revenues would be an amount equal to 50 percent of receipts from the payroll tax (plus the additional amount that would have been received if no alternative employer-employee plans had been established).

Workers under social security and Federal, State, and local government employees would be subject to the tax. However, State and local governments would not pay the employer tax.

In effect, the program would be financed roughly one-third by employees, one-third by employers, and one-third by Federal general revenues.

Funds would be held in two accounts within a Federal health insurance trust fund. The "general account" would be primarily the existing Medicare trust funds for the aged, combining the hospital insurance and the supplementary medical insurance trust funds. This account would be used for the payment of benefits for the aged and the disabled. A "special account" would be established to pay the benefits for the remaining population.

Standards for Providers of Services

Standards of participation for providers of services would be the same as those of the Medicare program. The Medicare standards are shown on page 225. In addition, the Department would be authorized to adopt additional standards for physicians dealing with requirements for continuing professional education, national licensing, and qualifications to perform major surgery and specialist services. These standards could be established only after considering those established by professional organizations, and receiving the recommendations of the Health Insurance Benefits Advisory Council, and following public hearings.

Reimbursement of Providers of Services

In the first 2 years of the program, providers of services would be reimbursed as they are under the present Medicare law. Under Medicare, hospitals, skilled nursing facilities, and home health agencies are reimbursed for the "reasonable cost" of services. However, payment for medical services would be based on "appropriate and reasonable charges" rather than "reasonable charges."

The Department would be required, in the interim, to study alternative methods of reimbursement to determine those methods which would best

control costs and utilization, improve the organization and delivery of health services, and assure that providers receive fair and reasonable compensation. Another possible objective would be to encourage medical societies or other organizations to assume greater responsibility for the quality, utilization and efficiency of care provided by their members, as well as the continuing education of professional and paramedical personnel. Following its study, the Department (with Presidential approval) would issue regulations concerning new reimbursement methods which would take effect in the third year of the program.

Of course, reimbursement would be subject to the new provisions and limitations included in P.L. 92-603 (H.R. 1).

Comprehensive Health Service Systems

Payment to qualified comprehensive health service systems (which are discussed later) would be based on the reasonable cost of services or could be a capitation rate for persons enrolled in the comprehensive system. Additional incentive payments are authorized if the average cost of services is less than the average cost of a comparable population group. Incentive payments are limited to a maximum of two-thirds of this difference in cost per member.

Providers of Drugs

Payment to drug providers would be based on "reasonable" charges including acquisition and dispensing allowances as determined by regulation. The physician's prescription would be filed with the drug provider. For a nonlegend drug, the physician would be required to certify that it is medically necessary.

Delivery and Resources

The plan authorizes the Department to contract for health services with comprehensive health service systems. These systems could be prepaid group practice organizations, other providers of health services, health insurance carriers, or a combination of them.

A comprehensive health service system is defined as one which provides health care to an identified population in an area, directly or through contractual arrangements with other providers. It must furnish all services covered under the Government program without any cost sharing by the patient, and the following additional services: a full range of prescription drugs, skilled nursing services without regard to the requirement concerning prior hospitalization, and immunizations and other approved services. The system would also need to meet the following requirements:

(1) it must assure the availability of services to enrollees, continuity of care, and appropriate referral and transfer of patients;

(2) all persons in the area may enroll, and it would encourage enrollment from a broad range of socioeconomic groups;

(3) preventive health services and health education are provided;

(4) a committee of physicians is established to consult with membership representatives, fix the professional policies, supervise the delivery of services, and review the utilization of health services;

(5) employment and training are given to allied health personnel;

(6) the premiums charged for noncovered services are reasonable; and

(7) the system is approved by State and areawide health planning agencies.

Financial Assistance to Comprehensive Systems

The Department is authorized to provide loans, grants, and technical assistance to comprehensive health service systems as follows:

(1) Grants and technical assistance to pay 80 percent of the cost of planning a comprehensive health service system. (Application for these grants could be made by a hospital, school, an insurance organization, or a community group.)

(2) Grants of 80 percent of the non-Federal share (the funds that the sponsor of a project ordinarily contributes) required under the Hill-Burton program for construction of hospitals and medical facilities.

(3) Grants of 50 percent of the cost of construction of needed ambulatory-care facilities, and loans at 3 percent interest for the remaining cost.

(4) Payment of the operating deficit of an approved system during its first 5 years of operation, provided the organization is making reasonable progress toward becoming self-supporting.

(5) Special grants of 100 percent of costs, up to $100,000, would be available for planning comprehensive systems in poverty areas, or demonstration projects designed to develop new methods of delivering care.

STAGGERS BILL

The "National Comprehensive Health Benefits Act of 1973" was introduced by Representative Harley O. Staggers of West Virginia as H.R. 11345.

General Concept and Approach

The proposal would establish a three-part national health insurance program including (1) a plan requiring employers to provide specified private health insurance for their employees and their families, (2) a voluntary plan for individuals, and (3) a federally financed plan providing health insurance for aged, low-income, and medically indigent persons administered through Federal contracts with insurance carriers. The benefits of these plans would be the same.

State governments would have major responsibility for administering the health insurance program and regulating providers of health services and insurance carriers, in accordance with Federal regulations. The State would also regulate and assist health maintenance organizations (HMO's) which would provide comprehensive health care services to enrolled population.

COVERAGE FOR EMPLOYEES

The plan requiring employers to provide specified health insurance coverage for their employees would include a broad range of services, generally subject to cost sharing by the individual. Additional catastrophic benefits would become payable when expenses exceed a specified amount. Coverage would be purchased from private insurance carriers, with the premium cost shared by employers and employees. Federal subsidies to employers and employees would be available under certain circumstances.

Coverage

The coverage requirement would apply to all employers subject to the social security tax. Where two or more members of the family are employed (or an individual has more than one employer) coverage would be provided by the employer paying the highest wages.

The participation of employees would be voluntary. Employed persons eligible for an employer plan are not eligible for the federally contracted plan even though they meet the requirements of the Federal plan (except for the aged, all of whom would be under Federal coverage).

Coverage for employees whose job is involuntarily terminated would be continued for 60 days, but would cease when the employee became eligible for unemployment insurance. Workers receiving unemployment insurance would receive coverage through the Federal-State unemployment insurance system.

In addition, coverage would be continued without regard to the cause of termination of employment (including coverage for a deceased employee's family) for 60 days or longer, with the length of coverage period and the arrangements for payment determined by the State health commissions (SHC) (established in each State, as described later).

Self-Employed and Other Persons

Coverage under the proposal would be available on a voluntary basis at reasonable group rates for all self-employed and other persons who are not eligible for federally contracted coverage. Each State health commission would make arrangements for coverage for the residents of the State, in accordance with Federal regulations.

Benefit Structure

The required benefits of the program would be phased-in in two stages with the initial benefits effective 3 years after enactment of the bill and the permanent ones (referred to as comprehensive health care benefits) 6 years after enactment. The phasing of covered benefits is shown in table 1 and the benefit provision in table 2. The comprehensive health care benefits include the regular benefits and catastrophic expense benefits, which becomes effective under conditions explained later.

Approved plans may include additional benefits (or eliminate or reduce the cost sharing). These are not subject to the general requirements or subsidies of the program.

Any policies offering protection supplementary to that in approved plans must meet State standards designed to assure that they are not promoted in a misleading manner and that they provide a reasonable ratio of benefits paid to premiums collected (i.e., retention ratio).

The comprehensive health care benefits are generally subject to cost-sharing provisions requiring the patient to pay a flat dollar copayment or a percentage of the charges. The amount of the flat copayments would be increased (if the Consumer Price Index (CPI) for a year rises by 3 percent or more over the previous year) at the same rate as the rise in the CPI.

TABLE 1.--STAGGERS BILL: Effective date of benefits

Group	Type of benefits and effective date 1/		
	2 years	3 years	6 years
General population: Employees	----------	Basic health services. Catastrophic expenses.	Comprehensive health care.
Self-employed and others	----------	Basic health services. Catastrophic expenses.	Comprehensive health care.
Persons receiving unemployment insurance	Basic health services.	Basic health services. Catastrophic expenses.	Comprehensive health care.
Federally contracted insurance: Aged	Basic health services and Medicare Part A. 2/	Basic health services and Medicare Part A. 2/ Catastrophic expenses.	Comprehensive health care.
Low-income	Basic health services.	Basic health services. Catastrophic expenses.	Comprehensive health care.
Medically indigent	----------	Basic health services. Catastrophic expenses.	Comprehensive health care.

1/ The effective data refer to the full fiscal years beginning after the date of enactment.

2/ Medicare Part B would continue to be available on a voluntary basis as under present law.

TABLE 2.--STAGGERS BILL: Comprehensive health care benefits

Type of service	Regular benefits			Catastrophic expense benefit
	Benefit (in benefit period)	Cost sharing	Other information	
Institutional services				
Hospital inpatient	60 days	$5 per day	Special provision for mental illness, alcoholism, and drug abuse.	No cost sharing, no limit on days
Skilled nursing facility	30 days	$2.50 per day		No cost sharing.
Nursing home	60 days	$2.50 per day		No cost sharing.
Personal services				
Physicians' services:				
In home, office, and ambulatory center	50 visits per year	$3 per visit	Special provisions for mental illness, alcoholism, and drug abuse.	No cost sharing, no limit on visits.
In hospital and other institution	No limit	$2 per visit	Copayment applies only to attending physician.	No cost sharing.
Diagnostic services	No limit	20 percent	No cost sharing for enrollees in HMO's.	No cost sharing.
Health examinations	By regulation	None		
Immunizations	No limit	None		
Family planning services	No limit	None		
Well-baby care:				
Under age 1	8 visits per year	None		
Age 1 to 2	4 visits per year	None		
Age 2 to 5	2 visits per year	None		
Home health services	100 visits per year	$2 per visit		No cost sharing.
Dental services (for children):				
Examination and cleaning	1 visit per year	None	For children up to age 7; once child is covered, benefits continue to age 12.	No cost sharing.
Other services	Routine dental care, by regulation.	20 percent		No cost sharing.
Vision services (for children):				
Examination	1 visit per year	None	For children up to age 15; includes services of physician or optometrist.	
Eyeglasses	1 set per year	20 percent		
Other services and supplies				
Prescription drugs	Drugs necessary for specified conditions requiring expensive drug therapy, or especially important to the public health; by regulation.	$1 per prescription.	List of drugs to be shown by generic names.	No cost sharing.
Prosthetic devices	By regulation	20 percent	Includes hearing aids.	No cost sharing.
Medical equipment	By regulation	20 percent		No cost sharing.
Ambulance services	No limit	20 percent	Only when medically necessary.	No cost sharing.

The bill provides for preventive health benefits, to be established by regulation, and indicates that consideration to be given to providing physicial examinations as follows:

Age 5-24.....	One examination every 5 years
Age 35-39.....	One examination every 2 years
Age 40 and over.....	One examination each year

The regulations would also establish the services and diagnostic tests included in preventive health benefits and these could be varied for different age, sex, and other population groups.

Physicians' services are defined to include services of allied health personnel under the supervision of a physician.

Mental Illness, Alcoholism, and Drug Abuse

Special provisions would apply to care for mental illness, alcoholism, and drug abuse and dependence. Inpatient hospital care for these conditions is covered only if the condition is in an acute phase. Inpatient care is limited to 45 days (instead of the usual 60) but this special limitation would not apply to a patient enrolled in an HMO.

Outpatient care for these conditions is also covered, subject to the usual 50-visit limit and copayment of $3 per day. (The copayment may be waived, by regulation, for treatment of drug abuse or dependency.) Day care and similar part-time services are specifically covered, for a maximum of 120 visits per year. The bill states that the regulations governing the mental illness services should be designed to encourage the use of outpatient programs.

The benefits include skilled nursing facility services which are provided in lieu of hospital care to patients who require active treatment. (There is no requirement for a previous hospital stay.) Benefits also include nursing-home care providing a less intensive level of care (referred to as health-related custodial care) for patients with an incurable disease who are bedridden, require certain nursing procedures, or meet other conditions.

Catastrophic Expense Benefits

The catastrophic expense benefits would liberalize the conditions applicable to the regular benefits. They would eliminate the cost sharing for all benefits and remove the limits on the number of inpatient hospital days (except for care of mental illness, alcoholism, and drug abuse) and for all physicians' and other ambulatory services.

The catastrophic benefits would become effective and be payable when specified noncovered medical expenses reach a certain total (the expense limit), which varies according to family income and age. The expenses that would be counted in determining this expense limit are (1) premiums paid for an approved health insurance policy, (2) expenses for cost sharing, and (3) expenses resulting from the limitation on the number of inpatient hospital days (except for mental illness, alcoholism, and drug abuse), skilled nursing facility days, physicians' visits, and outpatient mental illness, alcoholism, and drug abuse services. Expenses incurred in the last 3 months of a year would be included in the next year's expense limit.

The family income classes (which are based on family size and income) used in determining eligibility for catastrophic benefits are the same as those used in determining eligibility for federally contracted coverage (see page 114). A separate set of limits is applicable to families with heads under age 65, and those age 65 and over. For the lowest income class, the expense limit is zero and the catastrophic benefits are always in effect. The expense limit for the highest income class is not specified, but is calculated as 15 percent of income. The limits are shown as follows:

Family income class	Expense limit	
	Under age 65	Age 65 and over
1	0	0
2	$300	$150
3	600	300
4	1,000	500
5	15 percent of income	

The expense limits would be increased (if the CPI rises by at least 3 percent in a year) at the same rate as the increase in the CPI.

The initial benefits, referred to as basic health services, are the same benefits required as basic health services required of federally assisted health maintenance organizations (HMO's). These benefits include physicians' services, hospital inpatient and outpatient care, diagnostic laboratory and diagnostic and therapeutic X-ray series, mental health services (45 outpatient visits and 21 hospital days), home health services, and preventive care (including dental care and eye examinations for children). The precise nature of these benefits and any limitations and cost sharing are not given further in the bill and would be established by regulations. The catastrophic expense benefits, when applicable to these initial benefits, would remove limitations and cost sharing made applicable to them.

Administration

The employer would purchase private health insurance for his employees from an insurance carrier qualified under the program. Also a health insurance plan must meet certain requirements to be eligible for the 10-percent subsidy for enrollees of an HMO, as described later.

Financing

The employer is required to pay at least 75 percent of the premium cost, and the employee the balance. Employers would receive subsidy payments from the Federal Government if their share of the premiums exceeds 4 percent of the average wages paid to employees. The subsidy would be equal to the amount of the excess, for a maximum of 10 employees.

If an employed person was also eligible for the federally contracted plan and his share of the premium contribution was larger than under the Federal plan, he would receive a subsidy from the Federal Government equal to the difference.

The premium for coverage for self-employed and other persons would be paid by the policyholder. Coverage for persons receiving unemployment insurance would be financed by the Federal Government.

10-Percent Subsidy

Covered employees, self-employed, and other persons would receive a Federal subsidy, if the family is registered with an approved HMO, of 10 percent of the group premium rate for covered benefits. The subsidy payment would be made to the HMO (or the carrier for the HMO).

COVERAGE OF AGED, LOW INCOME, AND MEDICALLY INDIGENT

The Federal Government would provide health insurance coverage for aged, low-income, and medically indigent individuals and families through contracts with insurance carriers. The permanent benefits would be the same as under the required employer plans, although the interim benefits would be phased in differently. The plan would be financed through premium contributions from the medically indigent and from Federal general revenues.

Coverage

Aged persons (65 and over) would be eligible for Federal coverage without regard to income or employment status, and eligibility for low-income

and medically indigent individuals and families would be based on family income and size, as follows:

Income class	Family size and income			
	Single individual	Family of 2	Family of 3	Family of 4 or more
1...	$0-$2,500	$0-$3,500	$0-$5,000	$0-$6,500
2...	2,501- 3,500	3,501- 5,000	5,001- 6,500	6,501- 8,000
3...	3,501- 5,000	5,001- 6,500	6,501- 8,000	8,001- 9,500
4...	5,001- 6,500	6,501- 8,000	8,001- 9,500	9,501-11,000

Note: Families are defined as parents and dependent children under age 19.

The families in class 1 are defined as the low-income group and those in classes 2, 3, and 4 as the medically indigent. The determination of income would be based on the adjusted gross income shown on the income tax return but specified kinds of income could be included or excluded, as determined by regulation, if they are considered as readily available for living expenses (or not so). Also income could be determined on a more current basis if necessary to prevent hardship.

The dollar amounts shown in the table would be increased (if the CPI in a year rises by 3 percent or more) at the same rate as the CPI.

Benefit Structure

The federally contracted insurance would provide the same permanent benefits subject to the same conditions as for employed persons, and these would begin 6 years after enactment of the bill (tables 1 and 2). Catastrophic benefits would also be payable, according to income class and age. The table of expense limits for catastrophic benefits (which also would be recalculated at the same rate as the increase in CPI) is repeated below:

Family income class	Expense limit	
	Under age 65	Age 65 and over
1.....	0	0
2.....	$300	$150
3.....	600	300
4.....	1,000	500

The initial benefits for the three groups under federally contracted insurance would be phased in, as described in table 1. The aged, among the first groups entitled to benefits, would initially receive the basic health services and continue to be covered under the Medicare hospital insurance program (Part A) and eligible to enroll in its voluntary supplementary insurance program (Part B). Medicare benefits would be payable to the extent that the benefits are not included in the basic health services under the new program.

Financing

The aged and low-income groups would not pay any premium for the Federal coverage. The medically indigent would pay an annual premium, according to their income class, as shown below. The amount of this premium contribution would be raised (if the CPI in a year rises by 3 percent or more) at the same rate as the rise in the CPI.

	Individual	Family
Class 2.....	$50	$125
Class 3.....	100	250
Class 4.....	150	375

The additional costs of the program would be appropriated from Federal general revenues--including the cost of the federally contracted insurance, the 10-percent subsidy, the subsidy for small employers, and the cost of coverage for the unemployed (all described previously), the administrative costs of the program, and a 5-percent reserve account. These costs would be based on past experience and expected changes in the cost of services, the number of low-income and medically indigent persons, the utilization of health services, and the amount of contributions from the medically indigent.

Administration

The Department of Health, Education, and Welfare would contract with insurance carriers for health insurance for persons eligible for Federal coverage. The carrier must meet all special requirements established by regulation and could include carriers underwriting an HMO or an HMO operating on a capitation basis, acting as its own carrier.

The negotiation of the contracts would not necessarily be subject to competitive bidding and other standard Federal contract requirements, but information about the proposed contracts would be made available to all carriers. Contracts to provide coverage in an area could be made with more than one carrier. Also, a contract could require a carrier to subcontract with other carriers, or a contract could be made with a combination of carriers (which have established a joint arrangement or organization for this purpose). The SHC could be used as an agent in negotiating contracts.

Enrollment

The conditions for enrollment of eligible families under the plan would be prescribed by Federal regulations. Periodic open enrollment periods would be held (which would be concurrent for the various carriers and HMO's offering federally contracted plans in an area).

The premiums of the medically indigent would be payable to the carrier, but the State commission (SHC) could be used as a fiscal agent for this purpose. As prescribed by regulations, a grace period, for a maximum of 90 days, would apply in event of nonpayment of premiums before the insurance could be terminated. However, delinquency or default could not affect the coverage of persons age 65 and over.

ADMINISTRATION AND REGULATION OF THE PROGRAM

Major responsibility for supervision of the program would be placed on the States which would administer it in accordance with Federal standards and regulations.

Administration

The primary Federal responsibility for the program would be lodged in the Department of Health, Education, and Welfare. The Department would be responsible for the establishment of Federal regulations, standards for qualified providers and carriers, review of State compliance with the program, evaluation of the program, liaison with national accrediting and related organizations, and annual reports to the President.

When proposing new or modified regulations, the Department would be required to issue a statement of the anticipated impact of the regulation on (1) the availability of care, (2) health resources and facilities, including HMO's, (3) the cost and quality of care, and (4) the practice of health professionals. The statement would also have to indicate possible alternatives to the proposed regulation and the reasons for their rejection.

A national health services advisory council consisting of the Secretary of HEW, and 20 members appointed for 4-year terms, would include representatives of providers of services and of consumers (with the latter to constitute a majority). The council would advise the Department on policy, and this would include prior review and comment on proposed regulations. It would make an annual report to the Department and the the Congress. The Department would be required to report to Congress its views on the council's recommendations about administration (if not adopted), and on their legislative recommendations.

State Administration

State responsibility for the programs would be placed in an independent State health commission (SHC) within the executive branch of the State government. The SHC would be composed of three, five, or seven members (with a maximum of two, three, or four members, respectively, from the same political party) appointed by the Governor for staggered 6-year terms. Representatives of the health care professions could not constitute a majority of the members. Members would be full-time employees, could not hold a financial interest in a health care provider, and could be removed only for cause.

The SHC would be advised by a State advisory council which would include representatives of providers (including HMO's, other providers, professional organizations and societies, and medical schools) and of consumers, with the latter constituting a majority.

State Health Care Plan

The major provisions relating to State administration of the program would be presented in the State health care plan which would include the regulations for providers of service and insurance carriers, including the regulation of HMO's.

The State health care plan would be developed by the SHC, in consultation with the advisory council, after giving the general public an opportunity to present its views. The plan would need to be approved by the Federal Government and a State with an approved plan would be considered a "participating State." Disapproval would be subject to a hearing and to review by Federal courts.

If the State failed to obtain an approved plan within 3 years after the year of enactment of the bill (unless it is granted an extension) the Federal Government could intervene and administer the program in the State. It could also suspend approval of the plan or parts of the plan (or bring civil suit in Federal Court) if an approved plan is not properly administered, or is later modified, so that it is no longer in compliance with law. These provisions are subject to hearings and appeals in Federal Courts. Also, individuals could bring suit in State courts to compel State compliance with the Federal law and regulations.

Federal grants would be available to cover the entire costs of developing a State plan. For administeration, the Federal contribution would be 90 percent of costs for the year before benefits begin, 85 percent for the first 2 years of the program, and 75 percent thereafter.

Relationship to Other Government Programs

Federal financing for the Medicaid program would eventually be limited to services not covered under the new program (but would remain in effect for various population groups and services during the phasing-in period). Federal regulations would establish a new minimum scope of services (in lieu of those required under present Federal law) and these would be designed to supplement the benefits under the proposal.

In general, Federal health care providers would be excluded except when they function as community institutions or agencies, as determined by the SHC. Also, the use of Federal funds to provide health services under other programs would not be permitted if these services are covered under the proposal.

Providers of Service

Standards for participation of providers in the program would be established by Federal and State regulations. The minimum Federal standards and related provisions indicated in the bill are as follows:

(1) Hospitals, skilled nursing facilities, and home health agencies (including facilities of HMO's) must meet the standards of the Medicare program. (See page 225.) To the same extent as under Medicare, approval by State agencies or accreditation by certain national organizations would be accepted.

(2) Home health services must be furnished by an HMO or by an agency meeting special regulations of the DHEW.

(3) HMO's and institutions can not be restricted by the State from providing services through direct employment of medical and other practitioners or through prepaid group practice or other arrangements (including prepayment, fee-for-service, or other basis).

(4) The use and qualification of allied health professionals as assistants to physicians and dentists must meet Federal standards (and these Federal Standards cannot be further restricted by State law).

(5) Providers of service would be required to comply with additonal Federal and State standards to be established by regulations concerning the quality, scope, and comprehensiveness of services. The SHC would review the performance of providers in these matters.

(6) Providers of service would be required to disclose information to the public about their charge schedules, hours of operation, and any license, accreditation, or certification held by the provider.

The SHC could take corrective action against a provider of service who fails to meet the standards and fulfill his other obligations, including suspension of payments for covered benefits (subject to hearing and court review).

Providers are prohibited, under penalty of Federal law, from soliciting or taking kickbacks or bribes in connection with covered services, or making rebates of fees or charges for referral of patients.

Health Planning and Facilities

The SHC would take responsibility for implementation and coordination of health facility planning including (1) plans developed under the State health care plan; (2) State, regional, and local plans under the Federal comprehensive health planning laws; and (3) plans under other Federal or State programs.

Construction, modernization, expansion (or rental, in certain cases) of health care facilities or services by hospitals, nursing facilities, HMO's, or other organizations would not be permitted unless approved in advance by the SHC and authorized by a certificate of need.

On request of the DHEW, the SHC would review and recommend on applications of providers and other organizations for grants and contracts under the proposal and under various Federal laws.

Study of Capital Needs

The national health service advisory council, mentioned above, would make a special study of the capital needs of HMO's and other providers to determine methods of supplementing current sources of capital financing. It would give consideration to financing capital needs from health insurance premiums, a tax on these premiums or appropriated government funds, and study methods of encouraging continuing contributions from non-Federal sources. It would also consider methods of properly allocating capital financing among the States and areas, with emphasis on the role of the SHC in such allocation.

Reimbursement of Providers of Services

Payments to providers of service would be based on approved charges of providers, in accordance with Federal and State regulations. The Federal regulations would prescribe a uniform system of accounting and would indicate the methods used, and the elements considered, in determining the financial requirements of providers of service and HMO's.

In accordance with these Federal regulations, the SHC would prospectively approve charges for institutional providers based on a review of their budgets. Charges for kinds of physicians' services provided in an institution which are generally available to all inpatients (such as radiologists and pathologists services) would be included in the institutions' budget and not as separate physicians' charges. Payment would not be made for duplicate or excessive services or in connection with facilities for which the capital expenditures were not approved by the SHC. Providers dissatisfied with the SHC's decisions would be entitled to a hearing before it. The approved charge schedule would be applicable to all qualified private plans and to federally contracted coverage. The SHC would also review charges of all licensed noninstitutional providers.

In general, the insurance carrier would pay the covered charges, and the patient would pay the cost sharing, to the provider. However, where a carrier insures an HMO (which is not on a capitation basis) the carrier would pay the covered charge to the HMO and collect the cost sharing from the patient. A carrier insuring an HMO on a capitation basis would pay the capitation amount to the HMO.

Regulation of Insurers

The Federal law would permit various kinds of organizations to qualify as insurance carriers under the program including organizations which pay for (or provide) health care on a group basis by contract, agreement, membership, or subscription arrangements. It could also include an HMO offering coverage on a capitation basis, acting as its own carrier. A qualified carrier must be authorized to operate by each State where it offers coverage and, if requested by the State, must participate in a State coverage pool. (These pools may be established by States to meet their obligation to make coverage available to all their residents, as described earlier.)

A qualified carrier must meet the Federal requirement that it have a reasonable ratio of the amount of benefits paid to the amount of premiums collected (the retention ratio). In determining the ratio for a particular group plan, consideration would be given to (1) the carriers' average ratio for all its group plans combined (2) the size of the covered group, and (3) the nonprofit or profit status of the carrier. The initial determination of the reasonableness of the ratio would be based on projections

and the DHEW would periodically review the actual experience of the plan.

For nongroup (individual) policies the ratio would have to be the same as the ratio for the smallest groups.

Subsidized Insurance Plans

To qualify for the 10-percent Federal subsidy for families enrolled in an HMO, a health plan must meet the following additional requirements as well as all other Federal and State requirements:

(1) Provide coverage and benefits without regard to health status (preexisting, current, or future), economic status, race, sex, occupation, age, or any conditions indicated in regulations (classification of risks for premium rate purposes would be permitted in accordance with actuarial principles).

(2) Provide for coordination of duplicate coverage, as prescribed by Federal regulations.

Regulation of Premium Rates

The approval and regulation of health insurance carriers, in accordance with Federal and State regulations, would (except where indicated) be administered by the SHC. Federally contracted plans, however, would not be subject to State regulations.

The SHC would be responsible for regulating the premium rates of carriers for qualified group insurance plans but (except for an HMO acting as its own carrier) regulation could be delegated to the State insurance department or other agency.

In addition, the SHC would enforce the following disclosure requirements for qualified carriers and plans:

(1) An annual audit of the carrier would be conducted by a certified public accountant and the audit report made public.

(2) Carriers would be required to disclose to the public the provisions of a qualified policy relating to its (a) benefits and exclusions, (b) premium rates, (c) whether, and under what conditions, HMO coverage is available, and (d) the percentage of the premiums expected to be paid in benefits.

(3) Carriers must provide to the DHEW and to the SHC reports and information, as requested, and make its records available for inspection.

In addition, in the event a carrier is found to be financially insolvent (or impaired) under State law, the SHC must provide arrangements for payment, guarantee, assumption or reinsurance of claims, and other obligations under a fund established or regulated by the State.

Amendments to the law or new regulations, enacted or issued in a year, which would affect the obligations or rights of carriers, would not go into effect until the following contract year (except where an earlier date was mutually agreeable).

Disputes and Claims

The SHC would provide hearings and settle disputes between individuals, providers of service, HMO's, and insurance carriers in the following situations:

(1) claims by individuals against a provider or carrier (or vice versa), where the disputed amount is $100 or more;

(2) allegation by an individual of the failure of providers to meet their obligations, where the failure is part of a pattern of similar conduct;

(3) claims by a provider against a carrier or HMO for payment of charges for services (or for capitation charges); or

(4) disputes among HMO's and providers.

Evaluation of the Program

A national uniform statistical program would be established by the DHEW. Each SHC would function as a center for the collection and analysis of health statistics and information, and providers, carriers, and HMO's would be required to report statistical information. (Safeguards would be provided to protect the confidentiality of identifying information.)

As prescribed by Federal regulations, the SHC would evaluate the health-related and economic effectiveness of its own activities, and of HMO's and other providers. The evaluation would include a comparison of utilization of services of HMO's and other providers. The evaluation and other reports required by regulation would be filed with the Department.

At the Federal level, the Department would evaluate all aspects of the program and could conduct studies of alternative methods of furnishing and financing health care.

HEALTH MAINTENANCE ORGANIZATIONS

The bill provides for the development and regulation of a system of health maintenance organizations (HMO's). The provisions and regulations generally applicable to the program, including those relating to providers of service and to insurance carriers, apply generally to the HMO's. Only additional and specialized provisions concerning HMO's are described below.

Establishment of HMO's

The SHC would have responsibility for encouraging the establishment of a system of HMO's in the State. It would assist various organizations wishing to establish approved HMO's by providing information and advice, and assistance in applying for Federal grants.

The SHC would issue certificates of approval to qualified organizations to operate as HMO's in geographic service areas. The HMO's, when applying for approval, would indicate their service area. The service areas need not coincide with existing political boundaries and could extend across State lines, and the SHC would assist in arranging with other States to monitor HMO's serving in more than one service area. Service areas of HMO's would be allowed to overlap.

Applications of organizations to qualify as an approved HMO would be evaluated according to the following criteria:

(1) The organization must have competent management and adequate finances, facilities, and personnel.

(2) The need for an HMO in the area must be justified.

(3) If an HMO is already established in the area, the need for an additional one must be justified, on the basis that it will be economically feasible and provide a choice of sources of health care to the population.

Approvals for HMO's would be issued after providing an opportunity for a hearing to take testimony from the applicant, other organizations proposing an HMO for the same area, and the public. The SHC (or another designated State agency) would incorporate the HMO under applicable State law.

Enrollment

The bill indicates that the HMO's should enroll persons who are broadly representative of the age, social, and income groups in the area.

Periodic open enrollment periods would be held, as determined by Federal and State regulation. Before the enrollment period, the HMO must disclose full information to the public about its operations and services. Generally, it must enroll all applicants living in its service area, not discriminate on grounds of race, age, occupation, or health condition, and make reasonable efforts to enroll persons assigned by the SHC. An applicant who is not accepted could obtain a hearing before the SHC.

For an organization with limited capacity, enrollment may be limited with the approval of the SHC on a first-applied basis, but only if other approved HMO's are available for persons who wish HMO coverage. Also, with the SHC's approval, a HMO could enroll persons living outside its area and other persons it is not required to enroll. The HMO would assist eligible enrollees to obtain federally contracted coverage.

Medical Services

The bill states that the services of the HMO would, to the extent possible, (1) emphasize health maintenance and health education, (2) assure continuity of care and appropriate referral, (3) provide maximum care on an outpatient basis, (4) make services readily available, and (5) furnish outpatient care in centers and offices accessible throughout the area.

To qualify as an HMO, the organization would be required to furnish basic health services, as described previously, and to the extent possible supplemental health services. The supplemental services are long-term care, vision care, dental services, mental health care, physical therapy and rehabilitative services, and prescription drugs (in all cases, these benefits are in addition to any included under basic services).

For persons covered under the insurance provisions of the program, HMO's would be required to assume responsibility for all benefits covered by the insurance. It must schedule a periodic health examination for each insured enrollee, and emergency and ambulance services must be made available at all times.

The HMO would also be required to provide health education services designed to encourage healthful living and proper use of services, especially for low-income and medically indigent enrollees, with special assistance given to persons with language or educational handicaps.

A continuing personal health record (including medical histories and other information) would be maintained for each enrollee and be made available to the HMO staff and other appropriate providers. These records would be transferred when a member transfers to another HMO. The health records (which could also be used for statistical purposes) could not be disclosed without the enrollee's permission, except when necessary for the administration of the program.

The HMO would be required to give emergency services to persons not enrolled with it and, if resources are available, could provide other services to nonenrollees.

Methods of Providing Services

The HMO could provide services directly through its own staff and facilities and through arrangements with other providers of services. Professional services may be provided by arrangements with medical groups or individual practice associations. A medical group is defined as an organization of individuals licensed in a State to practice medicine, dentistry, or other specified health professions) who engage in the coordinated practice of their profession, share medical records and equipment, employ allied health professionals, arrange for their continuing education and meet other specified requirements. An individual practice association is an organization which has prearranged arrangements for compensation of its professional members and, to the extent possible, also coordinates and shares services and engages in activities similar to those of medical groups.

Quality of Services

The HMO must establish a quality assurance system providing for review by physicians and other health professionals (1) the process followed in the delivery of health services and (2) the quality of the results obtained through the health services provided. The SHC would approve the quality assurance system and conduct continuing surveillance of its performance.

The HMO would coordinate needs for health personnel, and would set qualifications and performance standards for personnel at least equal to the standards established by professional organizations. It would also conduct in-service training, encourage the use of paramedical personnel, and conduct other activities designed to meet its manpower needs and improve the quality of care.

Charges and Reimbursement

Charges of HMO's would be approved by the SHC, based on the financial requirements needed to fulfill its responsibilities, in accordance with the general principles of reimbursement described previously.

Initially, the HMO could charge its enrollees either an annual capitation amount for all covered services for the year, or a separate charge for each service rendered. However, capitation must be made available to persons wishing to enroll on this basis within 5 years after the HMO's incorporation. The basic capitation amount would be based on a "community rating system." This is defined as a system under which the capitation rate would be the same for all enrollees, varied only by family size and to reflect differences in the administrative costs of enrolling individuals, small groups and large groups (as determined by DHEW regulations). Different capitation rates would be allowed also for federally contracted insurance under the program and for certain contracts with specified Federal, State, and local government agencies.

HMO's would be responsible for payment for medically necessary services provided to its enrollees by out-of-area HMO's and emergency services furnished by other providers.

While the HMO must assume full financial risk on a prospective basis for the provision of health services for its members, it may insure itself against (1) the cost of basic health services of more than $5,000 in a year for one member, (2) costs applicable to members receiving services while outside its service areas, and (3) part of its losses for the year, resulting from a significant underestimation of its costs for that year.

HMO's would be required to protect themselves against the risk of insolvency, under a method approved by DHEW.

Representation and Grievances

The HMO must be organized in a way which assures its membership an important role in policy making. It must establish an advisory committee to represent its enrollees (and additional subcommittees or separate committees to represent groups of members with special interests) and provide other methods of permitting them to express their views on its policies and operations.

Also, the HMO would be required to establish procedures for handling grievances of enrollees or applicants for enrollment (and maintain records of the grievances for inspection by the SHC.

Disclosure Requirements

HMO's would be responsible for keeping records and reports on financial matters, utilization of services, and results of quality assurance programs. These records would be available for inspection by the SHC for verification.

In addition, the HMO would annually issue a report to the DHEW (which would be made public) on the (1) cost of its operations, (2) pattern of utilization of services, (3) availability and acceptability of its services, and (4) improvement in the health status of its members, if this is known.

Enforcement Powers

If the SHC determines that an HMO is not complying with laws or regulations, it could direct the organization to correct the situation, take other action such as placing the HMO in receivership, or amend or repeal its approval. These orders or actions would be subject to hearings and court review. Also, other interested parties such as other HMO's and providers could initiate an action to amend or revoke the approval of an HMO.

Federal Grants

The bill states the policy of the Federal Government to provide technical and other assistance in the development of HMO's and authorizes, to the extent needed, funds for financial assistance for their planning, development, and initial operation. It specifically provides for grants for new or expanded outpatient care centers for HMO's. (These grants would also be available to other nonprofit or governmental providers.)

In providing this financial assistance (which would be subject to the conditions and terms generally applicable to similar Federal programs) the Government would consider the resources already available in various geographical areas and attempt to provide an equitable distribution of facilities. A maximum of 15 percent of the funds could be granted in any one State. For the first 5 years of the program, priority would be given to HMOs operating on, converting to, or planning to convert to, a capitation basis and thereafter only to such organizations. Applications for financial assistance must be approved by the pertinent SHC and planning agencies.

PELL-MONDALE BILL

"Health Benefits and Health Services Distribution and Education Act of 1973" was introduced by Senators Claiborne Pell of Rhode Island and Walter S. Mondale of Minnesota as S. 2796.

General Concept and Approach

The proposal would establish a program of required health benefits for employees as an obligation of the employer and at his expense. It also authorizes the creation of health services corporations which would provide comprehensive health services, build and operate health care facilities, and train health care personnel. In addition, regional health planning councils would be established in major geographic regions of the country.

Coverage of the Population

Businesses and organizations engaged in interstate commerce or affected by a Federal interest, including Federal, State, and local government agencies, would be required to provide coverage for their employees and their families. An exemption of up to 5 years could be given an employer if he can demonstrate undue hardship because of long-term wage contracts or other reasons.

Benefit Structure

Institutional services

Hospital inpatient care: 12 days a year covered, but excluding payment for the first 2 days.

Hospital outpatient care.

Skilled nursing home: 10 days a year for recovery from serious illness, accident, or surgery.

Personal services

Physicians' services.

Psychiatrists and Psychologists: 20 outpatient visits, but no limit if provided by a hospital, health maintenance organization, or community mental health center, or similar organization

Physical checkup: one diagnostic examination per year.

Optometrist services.

Audiologists, otologists, and otolaryngologists.

Podiatrists' and chiropractors' services: if important to maintain employability.

Laboratory, X-ray, and supporting services.

Prenatal and postnatal care.

Other services and supplies

Medical devices, appliances, and equipment: if important to maintain employability.

Prescription drugs.

The proposal also includes a catastrophic coverage provision which would provide coverage of medical costs exceeding 25 percent of an employee's annual gross income, as prescribed by regulation.

Medical or surgical services, which cannot practicably be furnished on a nationwide basis because of costs or lack of resources, would be excluded.

Administration

Benefits could be provided by employers under various arrangements including contracts with prepaid health care plans, prospective contracts with providers of health services, directly by the employer himself, or through other "economic and appropriate means." In addition, they could be provided through the health services corporations created under the bill, as described later.

The Department of Health, Education, and Welfare (DHEW) would be responsible for establishing regulations and standards for the program, and provide for hearing procedures in cases of denial of benefits. If a Federal court finds a person has been denied benefits by his employer, the President may withhold all Federal funds, services, or contracts from that employer.

Relationship to Other Government Programs

The bill excludes services provided under workmen's compensation and school health programs. Medicare and other existing Government programs would continue to operate. The Medicaid program would not pay for services covered under the new program.

Financing

Employers would provide the health benefits as a cost of doing business and without charge to employees.

Standards for Providers of Services

Regulations of the Department of Health, Education, and Welfare would--

(1) require that properly accredited professional health services and facilities be used,

(2) establish standards of quality for services, and

(3) insure that services be medically needed or be for a preventive purpose.

Reimbursement of Providers of Services

The method of reimbursement of providers of services would depend on the arrangements made by the employer for provision of health services, as described earlier.

Delivery and Resources

The bill provides incentives for creation of area health services and health education corporations. The corporations would provide medical services, operate health facilities, establish and operate medical schools and health care training schools and conduct related activities. They would provide comprehensive health care services, as well as the health benefits required under the bill, and could contract to provide health services under the Medicare and Medicaid programs. The corporation could purchase the facilities of existing health care providers, employ professional and nonprofessional personnel, and enter into agreements with providers of services. Medical services could be rendered through prospective contracts with providers, prepaid group practice arrangements, or under other "efficient and effective" arrangements.

If DHEW determines that a health services corporation is needed in an area, a corporation would be established in that area. It would be managed by a 15-man board of directors representing consumers, health professionals, health organizations, and the Department. Eight of these board members would be appointed by the Department and the remainder elected by the stockholders.

Financing of Corporations

Corporations would be for-profit organizations and would issue dividend-earning common and preferred stock with voting rights, and other certificates of indebtedness. Initially, common shares could be issued only to State and local governments and to health service providers, including institutions and physicians in the area. The initial price of common stock would be set by the board of directors, or in consideration of the value of health facilities and related properties transferred

to the corporation. The DHEW would establish property evaluation methods. Preferred shares could be issued to any person or organization, except those initially eligible to receive common shares. No shares could be redeemed or repurchased for 5 years after incorporation.

Federal Assistance

The bill provides for grants from the DHEW to the corporations for--

(1) initial organization and operation;

(2) financing health care for the poor;

(3) financing benefits for employees of small businesses and charitable organizations, if the DHEW determines that the cost of providing the benefits required under the program would cause financial hardship;

(4) subsidizing medical education, if personnel are in short supply;

(5) building and staffing medical care and medical education facilities where shortages exist; and

(6) developing improved health care delivery methods.

The Department may also make loans to corporations and guarantee their loans.

Corporations which do not make a profit could receive grants, loans, and interest subsidies or guarantees from existing programs under the Public Health Service Act, if their components (such as hospitals) would otherwise be eligible for such aid. The corporations would be given priority consideration for such financial assistance.

Requirements for Corporations

Corporations would need to meet the following requirements:

(1) provide comprehensive services to all persons in the area and assure continuity of care, referral, and consultation arrangements;

(2) would not discriminate against patients;

(3) maintain accredited hospitals and other facilities;

(4) employ allied health personnel;

(5) appoint physician committees to establish medical care standards, oversee delivery of care, and monitor and review utilization (including drugs);

(6) conduct university-related medical educational programs;

(7) cooperate in area planning and arrange for reciprocity among area corporations; and

(8) conduct health care delivery systems research.

Standards for Providers of Services

Standards for hospitals, skilled nursing homes, and home health agencies associated with the corporation would be similar to those under the Medicare program (see page 225).

Physicians and other health professionals associated with the corporations would need to meet the national standards established by the Department. Continuing education requirements would be established and major surgery and other specified services could be performed only by physicians who hold specialty certification (or were previously engaged in the specialty), meet standards set by the Department, and are recommended by their participating hospitals. Persons who received their education with financial assistance from a corporation would have to agree to work for the corporation for at least 3 years. Hospitals could not refuse to grant physicians staff privileges on grounds other than professional qualifications.

Establishment of Regional Planning Councils

Under a separate section of the bill, the DHEW would establish planning councils in the major geographic regions of the country. Council members would be appointed by the DHEW to represent the Department, governors of States in the regions, health corporations, medical personnel, and consumers of health services. The councils would develop plans for comprehensive health services and for allocating manpower and facilities in the regions. They would work with State and local planning agencies and approve their plans for construction of health facilities. They would also approve the budgets of the health services corporations which would be required to submit 5-year plans. No Federal funds could be spent on projects not approved by the councils.

ROY BILL

The "Comprehensive Health Insurance Act of 1974" was introduced by Representative William R. Roy of Kansas as H.R. 13603.

Most provisions of the bill are identical to those of H.R. 12684 introduced by Representatives Wilbur Mills of Arkansas and Herman T. Schneebeli of Pennsylvania and S. 2970 introduced by Senator Bob Packwood of Oregon. Like these bills, the Roy bill would establish a required employer plan and a State-operated assisted plan. However, the Mills-Schneebeli--Packwood bill amends the Social Security Act, while the Roy bill amends the Public Health Service Act. The Roy bill does not contain the modifications of the Social Security Act included in the other bills, the most important of which are:

(1) the modification of the Medicare and Medicaid programs,

(2) the inclusion of the Professional Standards Review Organization (PSRO) provisions, and

(3) the requirements for approval by State planning agencies of substantial capital expenditures in health care facilities.

FANNIN BILL

"The National Health Standards Act" was introduced by Senator Paul J. Fannin of Arizona as S. 3353.

General Concept and Approach

The proposal would establish a two-part program including (1) an employee health benefits plan requiring employers to offer specified private health insurance to their employees and (2) a federally financed plan operated by the States for low-income families. Both programs would offer the same scope of benefits, although employee plans could provide actuarially equivalent benefits in lieu of those specified. Both plans would include a health maintenance organization (HMO) option and review of services by the Professional Standards Review Organization (PSRO).

HEALTH BENEFITS FOR EMPLOYEES

The employee plan would require employers to offer to full-time and certain part-time employees a health benefits plan implemented through private health insurance or similar methods. The premium cost would be shared by employers and employees. Special insurance pools would be established for small employers and the self-employed.

Coverage

Coverage under an employer health plan must be offered to any employee not under the Medicare program who has been employed for 31 days and is

(a) considered a full-time employee;

(b) not considered a full-time employee but is expected to work at least 20 hours a week for at least 26 weeks during the next year, or has in fact met these work requirements in the past year.

The plan must cover the employee, the employee's spouse, and dependent unmarried children under age 21 (age 23 if a full-time student). However, the coverage of eligible children would continue for as long as they are suffering a covered illness or disability.

The requirement would apply to all employers including Federal, State, and local governments. At their option, employers could cover U.S. citizens employed abroad. If an employer-employee agreement providing health benefits is in effect at the start of the new program, the requirements would not apply until the agreement expires.

At the option of the employee, coverage under the plan would be continued for 31 days after termination of employment.

Benefits

The required services covered under the plan and the limitations on these services are shown in the following chart:

Benefits	Limitations
Institutional services:	
Hospital inpatient.....	No limit.
Skilled nursing facility.....	By regulation. Available only after hospital stay of at least 3 days.
Personal services:	
Physicians' services.....	No limit.
Laboratory and X-ray.....	No limit.
Outpatient physical therapy services.....	No limit.
Outpatient psychiatric care.....	Benefit limited to 2 visits per week and $20 per visit.
Other services and supplies:	
Prescription drugs.....	No limit.
Medical supplies and appliances..	No limit.
Ambulance services.....	When medically necessary.

Cost Sharing

All benefits would be subject to an annual deductible of $100 per person, with a limit of $200 per family. In addition, the following coinsurance would apply:

(1) Coinsurance for all services (except outpatient psychiatric care and obstetrical care) of 25 percent of the first $10,000 annual expenditures per family, or a maximum of $2,500 of out-of-pocket expenses.

(2) Coinsurance for outpatient psychiatric services of 50 percent of the first $10,000 annually per family, or a maximum of $5,000.

(3) Coinsurance for obstetrical care of 50 percent of charges, but with a maximum payment of $500 per birth.

Actuarial Equivalent Benefits

In lieu of the specified benefits, a plan may provide an alternative benefit package that is actuarially equivalent to the specified benefits. To be actuarially equivalent, the total expected claims cost of the plan must be equal to that of the specified package. Further, the expected claims cost for hospital inpatient care, physicians in-hospital services, outpatient surgical services, and laboratory and X-ray benefits in the alternative package must each equal the cost of the same benefits in the specified plan.

To adopt an actuarially equivalent plan, the employer must obtain a certificate indicating actuarial equivalency from a Fellow of the American Academy of Actuaries (or another actuary designated by the State insurance department) and file the certificate with the insurance department.

Administration

An approved health care plan must be adopted in writing and the employer must inform his employees of its availability. The plan may be provided by insuring with a carrier, on a self-insured basis, or benefits may be provided directly by the employer. Any plan not insured by a carrier must be specially approved by the State.

Employers with 25 or more employees are required to offer their employees an option of enrolling in an approved health maintenance organization (HMO) as an alternative to the regular plan. At his option, the employer may select for this purpose one or more of the available approved HMO's in the area. An approved HMO is defined as one that meets the requirements of the Health Maintenance Organization Act of 1973.

Insurance carriers who offer qualified employee health care plans are required to develop special plans to offer employers with less than 100 employees and to self-employed persons. These special plans may be developed in combination with other carriers and the bill suspends any antitrust laws which would prevent the establishment of insurance pools to provide such special plans.

Compliance

After providing an opportunity for a hearing, the State government could bring court suit against an employer who is not complying with the law. An employer found to have willfully failed to comply could be required to (1) pay a penalty of twice his cost of an approved plan and (2) reimburse employees' families for their out-of-pocket payments (or cost of other health insurance) for covered benefits during the period of noncompliance.

The Department of Health, Education, and Welfare is authorized to issue regulations concerning the employees health benefits program necessary for the efficient administration of the program.

Financing

The employer is required to pay at least 50 percent of the cost of the approved health care plan.

For employees who elect HMO coverage, the employer would pay the HMO an amount equal to his premium cost for insuring his other employees for required benefits. If the HMO charges a higher total premium, the employee can be required to pay the additional amount.

This program would provide benefits for families with incomes below specified levels. The program would be operated by the States using private insurance carriers to administer the plan. Enrollees would pay premiums according to family income, with none required for the lowest income group, and the balance of the cost would be financed by the Federal Government.

Coverage

The maximum family limit for eligibility would vary according to the family size, ranging from $2,622 annually for a one-person family to $8,439 for a seven-person family. The definition of family income would be established by regulations. The maximum limits for each family size are shown in table 1 (which also shows premiums and coinsurance, as discussed later) and can be identified in the fourth column under "50 percent of premium."

TABLE 1.--FANNIN BILL: Families eligible for the low-income plan, by family size, premium payable, and maximum coinsurance

Family size	No premium	Percent of premium			Maximum coinsurance 1/
		10	20	50	
	Maximum family income				
1.....	$2,098	$2,203	$2,308	$2,622	$131
2.....	2,633	2,765	2,896	3,291	165
3.....	3,229	3,390	3,552	4,036	202
4.....	4,137	4,344	4,551	5,171	259
5.....	4,880	5,124	5,368	6,100	305
6.....	5,489	5,763	6,038	6,861	343
7 or more.....	6,751	7,089	7,426	8,439	422

1/ Maximum coinsurance at the highest eligibility level; maximum coinsurance would of course be smaller for those with lower income.

Benefits

The types of services covered under the plan would be the same as under the plan for employees. There would be no deductibles, and the patient would pay coinsurance of 10 percent of the charges for services, but with the maximum cost sharing limited to 5 percent of annual family income (table 1). For example, a four-person family with income of $5,171 would pay a maximum of $259. However, this annual ceiling on cost sharing would not apply to outpatient psychiatric care (for which there would be no limit).

Administration

Each State would establish an agency to administer the plan. Families would file for eligibility (in a form established by DHEW regulations) with the State agency which would enroll the family with a State-approved administering carrier. Carriers participating in the employer plan are required to participate in administering insurance for the low-income population. They may do so in combination with other carriers and the bill suspends any antitrust law which prevents insurance pool arrangements among carriers for this purpose. The carriers would issue policies to eligible low-income families and would pay claims for benefits on their behalf.

Enrollees could at their option enroll in an approved HMO in the area.

Financing

Families would pay a premium according to family income. There would be no premium for the lowest income class and other families would pay a premium of 10 percent, 20 percent, and 50 percent of the full premium cost (where family income was more than 105 percent, 110 percent, and 125 percent, respectively, of the base income for the lowest income class). The premium required, by family income, is shown in table 1. The balance of the cost would be paid by the Federal Government.

The plan would be financed through State insurance pools, operated by the administering carrier. The pool would receive the premiums, Federal contributions, and other income and pay claims certified by the administering carrier.

An annual experience accounting would be prepared by the administering carrier and submitted to DHEW, the State, and all participating carriers.

All carriers would participate in any pool losses according to a formula designed by the administering carrier and approved by the State. The total losses for a year apportioned to carriers would be limited to 3 percent of premiums, with any excess borne by the Federal Government. If there is a gain, it would be retained in the pool and used to reduce future Federal contributions.

PROVISIONS AFFECTING BOTH PLANS

The provisions of the bill described below would be generally applicable to both plans of the proposal.

Relationship to Other Government Programs

The Medicare program for the aged and disabled would continue. Federal grants for the Medicaid assistance program would be eliminated. Workmen's compensation laws and most other government programs would not be directly affected.

Providers of Service

The conditions for providers of service to participate in the program would be the same as under the present Medicare program.

Professional Standards Review Organization

All services would be subject to review by the Professional Standards Review Organization established by P.L. 92-603 to review the use and quality of services under various health care programs.

LUJAN BILL - H.R. 8101

The "National Family Health Protection Act," was introduced by Representative Manuel Lujan, Jr. of New Mexico as H.R. 15006.

General Concept and Approach

Under the proposed program families would receive a health protection certificate from the Federal Government which would be used to obtain a private insurance policy providing specified benefits. The program would be financed by a surtax on Federal personal income tax and supervised by the Department of Health, Education, and Welfare (DHEW).

Coverage

All residents of the United States would be covered.

Benefits

The specified insurance would be issued for a 1-year period and would have to be guaranteed renewable. Some services would be subject to cost sharing. The major benefit provisions are listed below.

Type of service	Limit on benefits	Cost sharing
Institutional services:		
Hospital inpatient.....	No limit----------	First 120 days, none; 121-240 days, 20% of costs; over 240 days, 50% of costs. 1/
Extended care facility....		
Personal services:		
Physicians home and office visits.....	No limit----------	$50 annual deductible; maximum payment of $5 per visit.
Physician hospital visits.	No limit----------	----------
Home health services.....	No limit----------	----------
Laboratory and X-ray.....	No limit----------	----------
Other services and supplies:		
Medical equipment and supplies.....	No limit----------	----------
Ambulance services.....	No limit----------	----------
Maternity care.....	No limit----------	$100 annual deductible.

1/ However, after 365 days, cost sharing would be limited to 2 percent of family adjusted gross income in the year of illness.

Administration

The Department of Health, Education, and Welfare would be responsible for general administration of the program and use government, public, and private agencies to assist in operating the program.

Families would ordinarily apply for a health protection certificate on their Federal income tax return. (For this purpose, a family is defined as (1) an unmarried individual with no dependents or (2) two or more persons living together, related by blood or marriage, and at least one of whom is claimed as a personal exemption on the tax return.) Special applications could also be filed during the year in certain cir-

cumstances. The Department would issue certificates which families could use to purchase a specified health insurance policy from qualified private insurance carriers.

Qualified carriers would accept the certificates and issue the health insurance policies. To be qualified, a carrier would be required to be approved by the State, agree to accept the certificates as payment of premiums for policies, participate in assigned-risk pools, and make payments into the health protection reserve fund (described below).

The qualified carriers would redeem the certificates with the Department. They would receive the actuarial value of the certificates determined by the Department, as described below.

Under Department regulations, eligible families unable to obtain a qualified policy, because they constitute high medical risks, would be placed in a pool and assigned from the pool to qualified carriers.

Relationship to Other Government Programs

The bill repeals the Medicare and Medicaid programs. It also calls for a report from the Department on legislative changes needed in other Federal health care programs and for improvement of the proposed program.

Financing

The program would be financed by a 5-percent surcharge on adjusted income tax on the personal income tax return.

Each year, the Department would determine the estimated average amount of expenses under the qualified policies for the following year, that is, the estimated actuarial value of the policies. Once determined, this estimated amount could not be changed.

A health protection reserve fund would be established by the Federal Government and be used to make benefit payments under a policy when a carrier, because of insolvency or other reasons, is unable to do so. Qualified carriers would pay into the fund amounts needed to provide a satisfactory reserve.

Standards for Providers of Services

Providers of services would be required to meet the same standards as under the Medicare program.

Reimbursement of Providers of Services

Hospitals, extended care facilities, and home health agencies would be reimbursed on the basis of the reasonable cost of services, in a similar manner to the Medicare program.

Physicians' surgical services would be reimbursed on the basis of relative value scales determined by the Department, after consultation with the medical societies in each State. These payments could vary on a State basis.

Delivery and Resources

There are no provisions regarding these subjects.

GRIFFITHS-KENNEDY BILL

"The Health Security Act" was introduced by Representative Martha W. Griffiths of Michigan and Senator Edward M. Kennedy of Massachusetts as S. 3.

General Concept and Approach

The bill would establish a national health insurance program covering the entire population and providing a broad range of health services, with no payment required of the patient. The program would be financed by a Federal payroll tax on employers and employees, a tax on unearned income, and Federal general revenues. The program would be administered by the Department of Health, Education, and Welfare. The proposal includes provisions designed to reorganize the delivery of health services, improve health planning, and increase the supply of health care manpower and facilities.

Coverage of the Population

All residents of the United States would be covered, including aliens admitted as permanent residents or for employment. Alien residents employed by a foreign government or an international organization would be eligible for coverage under special agreements. Persons would be eligible for benefits without regard to whether they have contributed to the program.

Benefit Structure

Benefits would be as follows, with no limits on the amount of services, except as indicated, and with no cost sharing required:

Institutional Services

General hospital inpatient care.

Psychiatric hospital inpatient care: 45 consecutive days in a spell of illness.

Hospital outpatient care.

Skilled nursing home care: 120 days in a spell of illness; number of days may be increased, by regulation, for homes owned or managed by a hospital, and for all homes depending on the availability of funds.

Personal Services

Physicians' services (nonpsychiatric): Includes physical checkups, immunizations, well-child care, and family planning services.

Physicians' psychiatric services: 20 visits during a spell of illness, but without limit if furnished by a health maintenance organization (HMO), hospital outpatient department, or mental health clinic.

Dentists' services: In first year of program for children up to age 15 and, each year thereafter, extended to persons 2 years older (e.g., in the second year to age 17) up to age 25. Once eligible, coverage continues throughout lifetime. By regulation, coverage may be extended faster than indicated in the law. Within 7 years after enactment, a timetable for phasing-in the entire population must be established. In extending coverage, preference may be given (temporarily or permanently) to enrollees of approved HMO's and organized dental plans.

Podiatrists' services.

Home health services.

Laboratory and X-ray.

Other personal services: Psychological, physiotherapy, nutritional, social work, health education, and related services furnished by an institution, HMO, or other agency under contract.

Other Services and Supplies

Optometrists' services and eyeglasses: By regulation.

Medical appliances: Therapeutic devices, appliances, and equipment, as established by regulation. Expenditures to be limited to 2 percent of total expenditures of program, if possible.

Ambulance services: By regulation.

Prescription drugs: Drugs required for chronic conditions and for specified conditions involving financial hardship, but without this limitation if provided by an HMO or professional foundation.

Experimental services which, because of cost or shortages, could not be provided on a nationwide basis would be excluded.

Administration

The program would be administered by the Department of Health, Education, and Welfare. A 5-member, full-time health security board, appointed by the President with the consent of the Senate, would serve under the Secretary of Health, Education, and Welfare. Board members would have 5-year overlapping terms and no more than three could belong to the same political party. The board would be responsible for general administration of the program including policy and regulations, control of expenditures, and standards and reimbursement for providers of services.

A national advisory council, appointed by the Secretary, would advise the health security board on general policy, regulations, and allocation of funds. The council would include the chairman of the health security board and 20 members including representatives of consumers (who would constitute a majority) and of providers of services. A commission on the quality of health care would be established in the Department to recommend to the Secretary and the health security board standards relating to the quality of care.

The program would be administered through the regional offices of the Department and local health service areas. Regional and local advisory councils, comparable to the national advisory council, would advise the regional and local offices. Individuals or providers with grievances would be entitled to hearings, appeals, and judicial review in Federal courts.

Relationship to Other Government Programs

The Medicare program for the aged would be abolished. The Federal Government would not financially participate in the cost of covered services for the Medicaid, vocational rehabilitation, and maternal and child health programs. (The intent of this provision is that these programs not pay for covered services.) Services under the CHAMPUS program (for military dependents and retirees) would be limited to non-covered services.

Federal providers of services including the Department of Defense, Veterans Administration, and the Department of Health, Education, and Welfare facilities for merchant seamen, Indians and Alaskan natives would not be eligible providers under the national plan. OEO and HEW health centers would be eligible providers. Agencies providing school health services would also be eligible for reimbursement. Medical services under a Federal or State's workmen's compensation law are not affected by the proposal. The bill requires a study of methods of coordinating HEW and the veterans programs with the proposed plan.

Financing

The program would be financed by (a) a 1.0-percent tax on wages of employees and on unearned income, (b) a 3.5-percent tax on employers' payrolls, (c) a 2.5-percent tax on self-employment earnings, and (d) contributions from Federal general revenues equal to the total receipts from taxes. If a firm's current obligations for health benefits exceeds the 3.5-percent tax, it must absorb the employee tax up to the amount of its current obligation.

The total income of an individual subject to tax from wages, self-employment income, and unearned income would be limited to $15,000 annually (or 125 percent of the earning base used in the social security program, whichever is higher). For persons age 60 and over, the first $3,000 of unearned income would not be taxable. For an employer, the entire payroll would be taxed. In addition to workers under social security, Federal, State, and local government employees would be subject to the tax, but State and local governments would not pay the employer tax. Members of the armed forces would not be taxed.

The funds of the program would be held in a health security trust fund with three accounts: (1) a health service account to pay benefit costs, (2) an account for administrative costs, and (3) a health resources development fund. The present hospital and medical insurance trust funds of Medicare would be transferred to the new trust fund.

Standards for Providers of Services

The standards for participation by providers of services would be similar to those of Medicare, but would also include others. (Medicare standards are shown on page 225). In addition, all providers must agree that (1) services would be furnished without discrimination on the basis of race, color, or national origin, (2) no charge would be made to the patient for covered services, and (3) required information and records would be supplied.

Hospitals

Standards for general hospitals are similar to those under Medicare, with two additional requirements. Hospitals cannot refuse to grant staff privileges on grounds other than professional qualifications, and they must have a pharmacy (and a committee to supervise drug therapy).

Skilled Nursing Homes

In addition to Medicare standards, nursing homes must be affiliated with a hospital or HMO whose medical staff assumes responsibility for professional services in the nursing home.

Home Health Agencies

Standards are similar to Medicare. Agencies would need to be public agencies or nonprofit organizations.

Health Maintenance Organizations

To qualify as a health maintenance organization, an organization would need to provide services to an enrolled population through group practice or similar approved arrangements. The organization would be required to furnish all covered health services, except mental health and dental services. Institutional services could be furnished by arrangements with other providers. Premiums or other charges for noncovered services must be reasonable. It must accept all persons in the area who wish to enroll. The organization must provide preventative services, assure continuity of care, and make services readily available to enrollees. It must have a committee which would establish medical standards and review utilization and quality of services. The organization would also need to meet the general requirements of the program concerning continuing education of professional personnel, and other requirements (to be established) concerning quality of care. It must employ paramedical personnel to the extent possible. The organization would have to be nonprofit.

Professional Foundation

A professional foundation sponsored by a State or local medical society could qualify as a provider of service. The foundation, which would be organized on a nonprofit basis, would be required to furnish the same covered services as the HMO and could also provide other types of covered and noncovered services. The foundation must permit all qualified physicians to participate (including those not members of the medical society). It would take responsibility for compensating professionals and other providers furnishing services on its behalf on a basis it prefers (including fee-for-service).

The foundation would need to meet requirements similar to those for HMO's (described above) regarding open enrollment for the public, reasonableness of charges for noncovered services, and requirements for continuing education and quality of care. (The requirement that services be provided through group practice or similar arrangements is not applicable to the foundations.) Similar arrangements could be made to establish dental society foundations.

Other Health Service Organizations

Other types of organizations, including public or nonprofit agencies which provide comprehensive health care services, but not necessarily to an enrolled population, could qualify as providers. Also, organizations (such as community health centers) could qualify to furnish

primary medical care and make arrangements to furnish and coordinate other medical services.

Professional Practitioners

Physicians, dentists, optometrists, and podiatrists licensed in a State before the start of the program would be eligible to participate, but would need to meet requirements for continuing education established by regulations. National standards for professionals would be established by regulation for those licensed after the program began. A State-licensed practitioner who met the national standards would be considered qualified in any other State. Major surgery and certain other specialist care could be furnished only by qualified specialists. Services of professional practitioners provided in a nonparticipating hospital would not be covered.

Other Providers

An independent laboratory or radiology service or a provider of drugs, medical appliances, or ambulance services, would need to meet requirements of State law and additional ones established by regulation.

Utilization Review

The requirements for utilization review in hospitals and skilled nursing homes include all those of Medicare. In addition, the hospital utilization committee would report its findings, on request, to the Health, Education, and Welfare regional office. For skilled nursing homes, utilization review would be conducted by a State or local public health agency, under contract with the Department, or by the regional office.

For specified types of surgery, prior consultation and approval by a qualified specialist would be required.

Independent physicians and dentists in general practice must maintain records and make reports, as required by regulations, for purposes of medical audit.

Scope of Services

Participating hospitals and other providers (except individual practitioners) could be directed by the Department to add or discontinue covered services, provide services in a new location, arrange for transfer of patients and medical records, and establish coordination or linkages with other providers. Such an order could be issued only on the recommendation of, or after consultation with, the State health planning agency and is subject to hearings, appeals, and judicial review.

Reimbursement of Providers of Services

National Health Budget

Each year, a national health budget for the coming year would be established. The budget would be based on the cost of the program in the current year adjusted for estimated changes in the Consumer Price Index, population, and the number and capacity of providers. Consideration would also be given to the extent to which costs are being controlled by improvements in delivery. However, the budget could not exceed the estimated total receipts for that year from taxes and general revenues.

The budget could be modified if later estimates of experience indicated that tax receipts or expenditures differed significantly from the estimates or if an epidemic or similar event required higher expenditures. A needed increase in a budget would be promptly reported to Congress.

Allocation of Funds

Funds would be allocated to each region on a per capita basis for institutions, physicians' services, dental services, drugs, appliances, and other professional and miscellaneous services. The amount for each category would be based on that spent during the past year modified for estimated changes in various factors (as described previously). The regional funds would be further allocated on a similar per capita basis to the health service areas. The bill provides authorization to eliminate unwarranted differences in average costs of health service among the regions by curtailing increases in funds to high expenditure regions and increasing the availability of services in low expenditure regions.

General Hospitals

Hospitals would receive a predetermined annual budget under regulations establishing the costs and services to be recognized in the budget. A uniform accounting system would be required. The compensation of professional practitioners (such as pathologists and radiologists) associated with the hospital would be included in the budget.

Psychiatric Hospitals

A psychiatric hospital rendering primarily active treatment to patients would be paid on the same basis as a general hospital. Those also providing noncovered services (such as custodial care) would be paid a predetermined rate per patient-day for the covered services.

Skilled Nursing Homes and Home Health Agencies

Payments would be based on an annual budget, as for general hospitals.

Health Maintenance Organizations and Professional Foundations

A HMO or professional foundation would receive a per capita amount for enrolled persons for ambulatory services they are required to provide, based on the per capita allocation for the various services in the local area.

If they also provide hospital or nursing home care in their own facilities, they would receive an annual budget amount for these services. If they arrange for hospital or skilled nursing home services through other providers, they would be reimbursed on the basis of an amount per patient-day for services used by their enrollees. The organization or foundation would be entitled to 75 percent of any savings resulting from its lower utilization of institutional services (whether furnished by the organization or through other providers) compared to that of a similar population group.

As an alternative, the payment for hospital and nursing home care would be based on a reasonable per capita payment per enrollee, in which case the organization or foundation would retain any savings resulting from lower than estimated use of these services.

Other Health Service Organizations

Other organizations such as health centers and State or local health agencies could be paid by any agreed method, other than fee-for-service. Independent pathology laboratories or radiology services could elect fee-for-service, approved budget, or any other agreed basis. Methods of payment for other types of providers would be specified in regulations.

Payment to Professional Practitioners

The major methods of payment available to physicians, dentists, and other professionals would be fee-for-service, capitation, and salary.

Fee-for-service would be generally available to all. The amount of fees would be determined by fee schedules or relative value scales, prescribed by regulation after consultation with representatives of the professions. The administration of fees could be delegated to a medical or professional society (or an agency selected by the society).

Capitation would be available only to independent physicians and dentists in general or family practice. An annual amount would be paid for each person enrolled to receive all services from the practitioner. These professionals could receive fee-for-service payments for services to persons not enrolled with them on a capitation basis.

By agreement with the local or regional office, a practitioner could be paid a full-time salary, or he could receive a part-time salary as a supplement to other methods of compensation. By agreement, specialists could also be paid per session or per case.

From the predetermined fund for physicians, dentists, and other professional services for an area (based on the per capita allocation for these types of services in the area), funds would be allocated to professionals selecting salary, capitation, and fee-for-service. If, during the year, total payments for fee-for-service were greater than estimated, the amount of fees would be reduced proportionately.

The law authorizes experimentation with other methods of reimbursement if they would not increase costs.

Delivery and Resources

Preparing for the Program

Financial assistance would be provided, before the start of the program, for the purpose of increasing health planning, alleviating shortages and maldistribution of facilities and manpower, and improving the organization and delivery of health services. The appropriations for this purpose would amount to $200 million and $400 million, respectively, for the 2 years before the program begins. In addition, Public Health Service funds for State comprehensive and areawide health planning would be increased to the extent necessary.

After the program starts, all expenditures for improvement in delivery and resources would come from the health resources development fund (except as noted below). This fund would receive, in the first year, 2 percent of the total income of the program and this allocation would be increased by 1 percent (at 2-year intervals) until it reached its ultimate rate of 5 percent.

Health Planning

The bill directs the Department of Health, Education, and Welfare to undertake planning to improve the supply and distribution of manpower and facilities and the organization of health services. State comprehensive health planning agencies (approved under the Public Health Service Act) would be given primary responsibility for coordinating the work of health planning groups within the State and interstate health planning agencies. The Department would assume these functions in States that do not carry out their responsibilities.

The bill states that priority is to be given to the provision of ambulatory services on a comprehensive basis, including the development

of HMO's and the strengthening of coordination and linkages among providers of services.

Health Maintenance Organizations

Grants could be made to a public agency or nonprofit organization for up to 90 percent of the expenses of planning and developing a new HMO. In addition, loans could be made for the construction costs of a new HMO, up to 90 percent of cost. Existing HMO's could receive similar development grants and construction loans, for expansion of their facilities, to a maximum of 80 percent of costs.

In addition, the operating deficit of newly established or enlarged HMO's could be paid as long as 5 years, if the system is making progress toward self-support.

Under the special improvement grants provision of the bill, HMO's could receive grants for the (1) purchase of diagnostic and therapeutic equipment; (2) purchase of equipment and other expenses for improving methods of utilization review, budgeting, and recordkeeping; and (3) costs involved in improving coordination and linkages of services.

The grants for improvement of coordination and linkages would also be available to all hospitals, nursing homes, and other providers of services outside the HMO's.

Manpower Training

The health security board, consulting with State planning agencies, would establish priorities for education and training of health manpower. Funds for this training would be provided by contracts with educational or other organizations, and allowances could also be paid directly to students. Funds may be provided for training or retraining, as follows:

(1) Training of medical students for general or family practice or for specialties in critical shortage.

(2) Training for professional and paramedical occupations, if other Federal financial assistance is not available. Priority would be given to those professionals who agree to work in shortage areas and in HMO's.

(3) Development of new kinds of health personnel, especially those useful in connection with HMO's. The new occupations could include teaching of personal health care, liaison with health care organizations, and consumer representatives. Under this provision, additional grants could be made to study the usefulness of the new occupations.

(4) For members of disadvantaged groups who are training for health occupations, special remedial education could be provided and additional allowances paid to the students.

Other Federal Assistance

Financial assistance under the program could not be used to replace funds available under other Federal programs and the Executive Branch of the Government is directed to use these funds to further the objectives of the national program. The health security program could loan 90 percent of the non-Federal share (the funds which the sponsor of a project ordinarily contributes) required under another government program. Where a loan has been obtained under another Federal program, the health security program could pay the interest on the loan that exceeds 3 percent.

Home Care

The bill provides authority to make grants for pilot projects of home maintenance care, including homemaker services, laundry services, meals-on-wheels, and assistance in transportation and shopping.

DINGELL BILL

The "National Health Insurance Act" was introduced by Representative John D. Dingell of Michigan as H.R. 33. It is similar to the Wagner-Murray-Dingell national health insurance proposal originally introduced in 1943.

General Concept and Approach

This proposal would establish a national health insurance program covering almost all residents of the United States. Standard benefits are broad and they would be financed through payroll taxes and Federal-State general revenues. The program would be administered by the Federal Government but would be decentralized with major administrative responsibilities placed at the State and local level. The bill contains provisions designed to improve the supply, quality, and distribution of health manpower and facilities.

Coverage of the Population

Virtually all U.S. residents would be covered. Almost all employees and self-employed persons would be covered and all persons eligible for social security benefits would be protected. Funds appropriated for various Federal-State health care programs could be used to obtain coverage for recipients of public assistance and the unemployed.

Benefit Structure

The proposal permits broad medical benefits but, in implementing the program, benefits would be made available in accordance with a State plan. The standard benefits available without limit, except as indicated, are as follows:

Institutional Services

General hospital inpatient care: 60 days.
Psychiatric and tuberculosis hospital care: 30 days; length of stay can be extended by regulation if funding and facilities are adequate.
Hospital outpatient care.

Personal Services

Physicians' services.
Dentists' services.
Physical checkups: periodic medical and dental examinations.
Home health services.
Podiatrists' services.
Optometrists' services and eyeglasses.
Laboratory and X-rays.
Physical therapy and related services.

Other Services and Supplies

Medical appliances.
Prescription drugs: types of drugs which are unusually expensive.

If the national health insurance board in consultation with the national advisory medical policy council (both created by this bill) finds that available resources are inadequate to provide dental, home health, or certain other specified services, it may limit these services for a period. In the case of dental services, priority would be given to children.

Administration

The program would be administered at three levels of government--Federal, State, and local--with the major operating responsibility falling to the State and local jurisdictions. Each State would evaluate its health resources and capabilities and, in accordance with national guidelines, would develop a health care plan. The State plans would be submitted to the national health insurance board and, when approved, the board would contract with the State for the administration of the program within that State.

Federal Level

A national health insurance board with five members would be established in the Department of Health, Education, and Welfare. Three members would be appointed by the President to serve with the Surgeon General and the Commissioner of Social Security. The board would establish the regulations and standards for the program, supervise the States and allocate funds. If the board finds that a State is not complying with the provisions of its plan, the board can administer the program in that State.

A national advisory medical policy council would be established, consisting of the chairman of the national board and 16 members appointed by the Secretary of Health, Education, and Welfare. At least eight

members would serve as consumer representatives and at least six as representatives of providers of medical services. The advisory council would advise the board on matters of general policy and administration, establishment of professional standards, and other matters.

State and Local Levels

The administrative agency in each State would, if possible, be the same agency that administers its public health or maternal and child health programs. State plans would:

(1) provide for a State advisory committee with a majority of members representing consumers and the remaining members representing providers;

(2) establish local health-service areas and provide methods for selecting their advisory committees;

(3) provide for surveys of resources and needs of the State;

(4) give assurance that maximum use would be made of available health personnel and facilities and that funds would be allocated to local areas in such a way as to correct maldistributions and inadequacies.

Local area agencies, with the assistance of a similar advisory council representing consumers and providers, would administer the program at the local level, make payment to providers, and carry out related administrative duties.

Relationship to Other Government Programs

Initially, aged persons could receive those benefits of the program not provided under Medicare. The Department of Health, Education, and Welfare would be required to study the relationship between the national health insurance plan and the Medicare program and devise methods of incorporating Medicare into the national plan. Funds appropriated for Medicaid and other Federal-State assistance programs could be used by States to finance the cost of covering needy persons who do not make regular contributions required by the program.

Financing

A personal health service account would be established to hold the funds of the national program. The account would receive an amount equal to 3 percent of total earnings. (The definition of earnings would be the same as under the social security law.) In addition, for the specific purpose of financing the cost of dental, home health, and certain other services, the account would receive an additional amount

equal to one-half of 1 percent in the first year of the program. This additional amount would increase to an ultimate rate of 1 percent in the third year. Further, in the first year of the program, an additional 1 percent of earnings would be appropriated as a reserve and the bill authorizes any additional funds required to meet expenditures. While the bill does not specify the source of any of these funds, the apparent intent is that they be obtained from a payroll tax on employers and employees covered under social security.

Standards for Providers of Services

Standards of participation for providers of services under the program would include the following:

Hospitals and Institutions

Hospitals or institutions qualified under State standards could participate in the program. If a State has not established standards, the national board would establish them for the State.

Professional Practitioners

Physicians, dentists, and podiatrists legally authorized to practice in a State would qualify. Specialists would be required to meet standards established by regulation.

Nurses

Professional nurses registered in the State would qualify. Practical nurses qualified under State standards or standards established by regulation could provide home health services.

Reimbursement of Providers of Services

The national board would allocate funds among the States for each of five classes of health services (medical, dental, hospital, home health, and auxiliary) on the basis of population, availability of health resources and the costs of services, as indicated in the State plan. The allocation would be designed to assure that adequate health benefits are provided in all States and to improve the adequacy of services where they are below the national average.

The State agencies would contract with providers of care for services under the program and determine rates of payments. The payments could be administered by the State agency or the local health-service area. Nonprofit health-service insurance plans could be used as agents or intermediaries.

Hospitals and Other Institutions

Hospitals and other institutions would be reimbursed on the basis of reasonable costs. In calculating costs, the payment for room and board would be based on the least expensive multiple-bed accommodations. A maximum rate for hospitalization could be established (after consultation with representatives of provider organizations) and it could vary according to locality and class of service.

Professional Practitioners

Physicians and dentists could select reimbursement under various methods, including fee-for-service (based on a fee schedule), capitation (with maximum limits on the number of registered patients), full- or part-time salary, or a combination of these methods. Specialists could choose the same methods and, in addition, payment on a per session or per case basis.

Rates of payment would be geared to local conditions. In deriving the rates of payment under the various methods, consideration would be given to the annual income that would accrue to practitioners. Further, reimbursement would be designed to provide incentives to practitioners to advance in their professions, pursue postgraduate studies, maintain high-quality service, allow for adequate vacation, and practice in areas where their services are needed.

Home Health and Other Services

Methods of payment for home health and other services would be determined by the State agency administering the program.

Delivery and Resources

The national health insurance board, after consultation with the national advisory council and other Federal agencies, is authorized to make grants-in-aid for training and education to students and educational institutions. To finance this program, $10 million would be available for the first year of the program, $15 million for the second, and for each following year an amount equal to one-half of 1 percent of benefit expenditures in the previous year.

MILLS-KENNEDY BILL

The "Comprehensive National Health Insurance Act of 1974" was introduced by Representative Wilbur D. Mills of Arkansas as H.R. 13870 and Senator Edward M. Kennedy of Massachusetts as S. 3286.

General Concept and Approach

The bill would (1) establish a new national health insurance program for the general population and (2) improve the present Medicare program for the aged and disabled. Both programs would provide the same scope of benefits including catastrophic protection, but a new range of long-term services would be added to the Medicare program.

Both programs would be administered by an independent Social Security Administration using private insurance carriers to process claims. The bill introduces new methods of reimbursement of providers of service and additional standards and regulation of providers.

A health resources development board would be established to improve health planning and the financing of health facilities and manpower. The bill also includes provisions designed to encourage the development of supplemental private health insurance.

NATIONAL HEALTH INSURANCE PROGRAM

The new national health insurance plan would cover persons who are insured under social security, working full-time, or eligible under certain assistance programs. It would provide a broad range of hospital, medical, and preventative services and be financed mainly by special taxes on earnings, unearned income, and certain assistance payments.

Coverage of the Population

The bill would provide coverage under the new health insurance program to the following groups during the period indicated:

(1) Persons currently or fully insured under the social security program and their spouses and dependent children under age 18 (or full-time students under age 22) would be eligible for benefits during the period they continue to be insured. In calculating credits for insured status for health insurance,

specified unearned and other income as well as earnings now covered by social security would be included, as described later. 1/

(2) Persons under age 65 eligible for cash benefits under social security would be covered for health insurance while eligible for these cash benefits. This provision would also extend health insurance coverage to persons who, except for their age, would be eligible for social security cash benefits as an aged widow or widower.

(3) Persons working at least 25 hours a week would be eligible for health insurance from the beginning of the week they meet the 25-hour requirement until 3 weeks after they no longer met this requirement.

(4) Persons receiving self-employment income and/or unearned income totaling $400 for a year would be covered for health insurance for that year. Eligibility could be established at the start of the year by notification of the expectation of receiving this income.

(5) Individual and families receiving payments under the programs of aid to families with dependent children (AFDC) or supplemental security income (SSI) would be covered while under those programs.

Persons eligible under the Medicare program would not be covered by the new national health insurance program.

1/ To be currently insured, a person needs social security credit for at least 1-1/2 years within the past 3-year period. To be fully insured, he needs at least 1 quarter of coverage for each calendar year elapsing after 1950 or (if later) after the year in which he attained age 21, up to the year he becomes entitled to benefits. A person who has 10 years of work is fully insured for life.

Benefit Structure

The benefits under the plan include hospital, skilled nursing facilities, physicians, home health, and diagnostic services, and such additional benefits as certain prescription drugs, preventive care, and special services for children, as shown in table 1.

The program would not exclude benefits for pre-existing medical conditions, require any waiting period before benefits become payable, or impose any maximum limit on the total dollar amount of benefits payable on an annual, lifetime, or other time basis.

Mental Illness

Under special limitations applying to mental illness, inpatient care in a psychiatric hospital is limited to 30 days in a year. Partial hospitalization (such as day or night care) is specifically covered, limited to 60 days per year.

The annual maximum amount of benefit payable for outpatient mental illness services would be initially calculated by estimating the total charges for 30 visits to a private practitioner for the treatment of mental illness. (For example, 30 visits at say $30 a visit, or $900).

However, the amount determined by this calculation represents the maximum amount of benefits payable annually for care in an approved comprehensive community care center. For care by a private practitioner or in other settings, the annual benefits payable would be one-half that maximum amount. (In the illustration above, $450.)

In either case, no limit is set on the actual number of visits in any setting. (The reference in the bill to 30 visits is given only to provide a basis for calculating the annual maximum dollar amount of benefits that would be payable.)

Outpatient Drugs

Coverage of outpatient drugs would be limited to a list of drug categories, shown in the bill, representing mainly drugs used in the treatment of certain chronic illness but also including oral contraceptives. A formulary committee, described later, would compile the formulary--the list of covered drug entities and dosage and strength information appropriate to them. In compiling the formulary, the committee would be guided by information concerning the (1) clinical equivalence of various drug entities and (2) the relative usefulness of various drug entities in treatment of illness.

TABLE 1.--Covered services under the proposal

Type of service	Limit on benefits	Other information
Institutional services		
Hospital inpatient	No limit	Special limitations for mental illness.
Skilled nursing facilities	100 days per year	Available after a hospital stay of 3 days or more.
Personal services		
Physicians' services	No limit	Includes home, office, and hospital visits, Special limitations for mental illness.
Home health services	100 visits per year	----------
Laboratory and X-ray	No limit	----------
Outpatient physical therapy services	No limit	----------
Podiatrist services	No limit	Excludes routine foot care.
Preventive services:		
Family planning services	By regulation	Includes services and supplies.
Prenatal and maternity care	By regulation	----------
Well-child care	By regulation	For children under age 6.
Special services for children:		
Dental services (for children under age 13)	No limit	Routine services including examinations, fillings, extractions and replacements; excludes orthodontia.
Vision services (for children under age 13)	By regulation	Includes eye examinations and eyeglasses.
Hearing services (for children under age 13)	By regulation	Includes examinations and hearing aids.
Other services and supplies		
Prescription drugs	No limit	Limited to list of drugs of types used in treatment of chronic illnesses and other specified conditions.
Blood and blood products	No limit	----------
Prosthetic devices	No limit	----------
Medical equipment and supplies	No limit	----------
Ambulance services	By regulation	Only when medically necessary.

Cost Sharing

Generally, payment for all covered services would be subject to a common deductible of $150 annually per person (but with no further deductible after two members of a family have met the deductible for the year). However, the preventative services and the special services for children indicated in table 1, when provided on an outpatient basis, would be exempt from the deductible requirements. In addition, payment for all services, including those exempt from the deductibles, would be subject to a coinsurance rate of 25 percent, except for drugs which would be subject to a copayment of $1 per prescription.

Reduced Cost Sharing for Low Income Families

In general, the maximum amount of cost sharing (deductibles and coinsurance) would be limited to $1,000 per family in a year, after which no further cost sharing would be required for any members of the family. However, the cost sharing requirements would be waived entirely for families with annual income below the following specified levels.

Family size	Family income
One	$2,400
Two	3,600
Three	4,200
Four	4,800
More than four	4,800 plus $400 for each additional member

Further, the annual maximum cost sharing would be limited to 25 percent of family income above these specified levels, up to the $1,000 family limit. The maximum amount of cost sharing payable under these provisions for families of various sizes and income levels is illustrated below.

TABLE 2.--Maximum cost sharing payable, by family size and income

Family income	Family size			
	1	2	4	6
$2,000.....	0	0	0	0
$3,000.....	150	0	0	0
$4,000.....	400	100	0	0
$5,000.....	650	350	50	0
$6,000.....	900	600	300	100
$7,000.....	1,000	850	550	350
$8,000.....	1,000	1,000	800	600
$9,000.....	1,000	1,000	1,000	850
$10,000.....	1,000	1,000	1,000	1,000

While the bill provides for application of this test on an annual basis, it provides authority to use a different period if it more appropriately reflects family income at the time the medical bills are received.

For cost sharing purposes, a family is defined as two or more persons related by blood, marriage, or adoption living in the same residence, but excluding persons under the Medicare program. The definition of family income for cost sharing determinations is similar to the definition under the Supplemental Security Income (SSI) program (and is not identical with income taxable under the bill). Income would include both earned and unearned income--including wages, self-employment income, assistance, support and maintenance, annuities, pensions, veterans payments, workmen's compensation, social security, and unemployment insurance. Also included are rents, dividends, interest, alimony, inheritances, and life insurance payments exceeding $1,500. Excluded from consideration are small gifts, specified small amounts of income received on an irregular basis, and certain funds received for educational purposes such as scholarships, loans, and fellowships.

The $1 copayment for covered drugs would not be considered in calculating the $1,000 limit or the income-related reduction of cost sharing.

Financing

The program would be financed by new special taxes similar to the taxes imposed on earnings under the Medicare program, but also including

unearned income and certain assistance payments. In addition, certain payments would be made to the program from Federal and State general revenues.

Special Taxes

The total amount of income subject to the special taxes would be limited to $20,000 annually for the (1) combined income of a husband and wife eligible to file a joint return (2) the income of any other individual, and (3) the employer tax on the wages of any one worker. The income subject to the special tax would be taxable in a specified order and at specified rates as indicated in table 3.

TABLE 3.--Special taxes, by type of income, order of payment, and tax rate

Order	Type of income	Recipient of income		Other payor		
		Payor	Tax rate	Payor	Tax rate	Total tax rate
1	Wages	Employee	1%	Employer	3%	4%
2	Self-employment income	Self-employed person	2 1/2%	--	--	2 1/2%
3	Unearned income	Recipient	2 1/2%	--	--	2 1/2%
4)	AFDC	Recipient	1%	State Government	3%	4%
4)	SSI	Recipient	1%	Federal Government	3%	4%

For example, a person (or husband and wife) with both wages and other income would pay only on wages, if the wage income was at least $20,000 for the year. Otherwise, he would pay on any self-employment and/or unearned income received, up to $20,000 maximum.

Tax on Wages

The wages subject to tax would include all employment now compulsory covered under Medicare and, in addition, wages of employees of the Federal Government, State and local governments, and nonprofit organizations. Pay of members of the Armed Forces would be excluded.

The bill indicates its intention that the current obligation of employers to pay for health benefits for their employees should not be reduced because of enactment of the proposal. Employers whose per capita costs for health benefits at the start of the program exceed the cost of their payroll taxes under the proposal would be required to absorb the employees share of the payroll taxes up to the amount of their current obligations. If the employer's obligation, under any agreement in effect at the start of the program, is greater than the total combined employee-employer taxes and any supplementary health benefits provided, the employer must pay his employees the excess amount involved (at least for the duration of the agreement). By mutual agreement, this requirement could be met by providing other types of benefits of equivalent value.

Unearned Income

Unearned income subject to the special tax would include all income included in adjusted gross income under the Federal income tax law (with rents, dividends, interest, and royalties specifically mentioned). In addition, any payment received as an annuity, pension, retirement or disability benefit--including veterans compensation, OASDI payments, railroad retirement annuities and pensions, and unemployment insurance payments would be included. Persons eligible under the Medicare program and persons under the age of 18 would be exempt from the unearned income tax.

AFDC and SSI

As indicated in table 3, cash payments under the AFDC and SSI programs would not be treated as other unearned income. They would be subject to tax at rates for the recipient and the government similar to the employee-employer tax rates.

Federal General Revenue

Federal general revenues would finance the cost of eliminating or reducing the cost sharing for low income families, as described earlier, including the related administrative expenses and loss of interest to the trust fund attributable to those provisions.

State General Revenues

In States where the 3-percent tax payments on behalf of AFDC recipients (as described above) for 1975 were less than the 1973 costs for Medicaid programs, excluding costs for skilled and intermediate care facilities, the State would pay an amount equal to the difference. A similar comparison of 1973 Medicaid expenditures would be made for 1976 and each succeeding year and the State would pay any difference for those years. (It is expected that, where States are initially subject to a general revenue contribution under these provisions, in most cases the 3-percent tax payment would eventually rise to a level where no further contribution would be required.)

Withholding of Assistance and Unearned Income

The State agency administering the AFDC program, and the Federal agency (SSA) administering the SSI program would withhold the recipients' share of the special health insurance tax from the cash payment due their recipients. Also, the DHEW could make arrangments with other public and private agencies (for example, agencies paying pensions, unemployment insurance, etc.) to deduct and forward recipients' taxes due on their payments.

National Health Insurance Trust Fund

A newly established national health insurance trust fund would receive the special taxes and the Federal and State general revenues payable under the proposal. The fund would be managed by a board of trustees in a manner similar to the trust funds of the Medicare program.

MEDICARE

The bill would improve the benefits of the present Medicare program and revise reimbursement methods, standards for providers and certain administrative mechanisms to conform with the proposal national health insurance program.

Coverage

The coverage provision of the Medicare law, which covers insured aged and disabled persons, would not be changed. Persons age 65 and over not insured for Medicare would receive benefits under the proposed national health insurance program if they qualify under one of its eligibility provisions.

Benefit Structure

The proposal would conform the benefit structure of Medicare to that of the new health insurance program by (1) adding outpatient drug benefits, (2) eliminating the limit on the number of covered inpatient hospital days, (3) eliminating the requirement that home health benefits be available only after a hospital stay, and (4) eliminating the special deductible on blood and blood products. A new range of long-term care services would also be added to Medicare, as described later.

The general cost sharing provisions of the Medicare program would not be changed. 2/ Unlike the plan for the general population, the newly added outpatient drug benefit would not be subject to any deductible, but only to the $1 copayment per prescription.

However, the same provisions of the new program for elimination or reduction of cost sharing for low income families would apply to Medicare families, as would the maximum on cost sharing of $1,000 per year applicable to other families. (See table 2.)

Financing

The tax provisions of the Medicare program would not be changed. In 1974, the Medicare hospital insurance program is financed by a tax of 1 percent each on wages for employees and employers and on self-employment income, on earnings up to a total of $13,400 annually for an individual. The tax rates are scheduled to rise, in steps, to 1.45 percent in 1986 and the amount of annual earnings taxable is raised automatically each year according to rises in wage levels, as shown in social security records. Other income is not subject to this tax.

2/ In 1974, under the hospital insurance part of Medicare, the inpatient hospital deductible was $84, and the hospital copayment required after 60 hospital days was $21 daily ($42 a day during the lifetime reserve available after 90 days). For SNF facilities, $10.50 is required after the 20th day. The amount of the deductible and the various copayment rates (which are calculated as a percentage of the deductible) are increased each January in proportion to the increase in per diem hospital costs.

Services under the supplementary medical insurance part of Medicare, which covers physicians services and various outpatient services, are subject to a $60 annual deductible and 20 percent coinsurance.

The supplementary medical insurance program is financed by premium contributions of enrolled persons of $6.30 monthly in 1974 (scheduled to rise to $6.70 in 1975) which are supplemented, as needed, by payments from Federal general revenues. The premium may be raised each year, as medical costs rise, but the percentage increase in the premium cannot be larger than the percentage increase in cash social security benefits resulting from a general benefit increase.

The cost of the outpatient drug benefit added to the Medicare program would be financed from Federal general revenues.

MEDICARE LONG TERM CARE BENEFITS

The bill would add to the revised Medicare program a new range of long-term care services administered through special State and community organizations and financed by enrollees premium payments and Federal and State general revenues. These benefits would become available 1 year later than the start of the proposed program.

Coverage

Coverage would be available on a voluntary basis to aged and disabled persons who have enrolled in the voluntary supplementary medical insurance part of Medicare. The persons must also be (1) under the Medicare hospital insurance program, (2) have attained age 65 and be either a citizen or a permanent alien resident for at least 5 years or (3) be eligible for SSI benefits. Persons could enroll during the first 3 months they first become eligible for Medicare, or during the general enrollment period held in the first 3 months of each year. Once a person has disenrolled, he could never enroll again.

Benefits

The benefits of the long-term care service program and the requirements and limitations are as follows. However, any of the services also covered under the regular Medicare program would be provided under Medicare, with the long-term program covering only additional (noncovered) services.

(1) Home health services, as these services are defined under the Medicare law.

(2) Homemaker services, including preparing and serving meals in the beneficiaries' home, and other services needed to maintain the home in a condition which facilitates the furnishing of other covered long-term

services. Homemaker services would only be available for persons receiving at least two other covered long-term services.

(3) Nutrition services including meals-on-wheels and similar services, but only if receiving at least one other covered long-term service. Also, the services of a professional nutritionist could be provided, if the need for such service is certified by a physician.

(4) Outpatient services provided by an approved community mental health center.

(5) Day care--care provided on a regular but less than 24-hour-a-day basis in a place other than the person's home.

(6) Foster home care--full-time care in a family setting in a home approved by the State long-term care agency. An approved home cannot include more than three persons unrelated to the family.

(7) Long-term-institutional care services including (1) skilled nursing facility (SNF) services, as defined under Medicare and (2) care in an intermediate care facility (ICF) for persons who do not require services in a hospital or SNF, but have a physical or mental condition requiring services (in addition to room and board) available only through institutional care.

Skilled and intermediate care facilities must have a transfer agreement with a community long-term center (as described below), be licensed under State law and meet other specified requirements. They must also have arrangements for meeting medical emergencies, meet the requirements of the 1973 Life Safety Code of the National Life Protection Association and meet any additional requirements established by Federal regulation.

Cost Sharing Provisions

All services would be provided with no payment by the patient, except as indicated below.

(1) Beginning with the seventh consecutive month a patient is receiving institutional services (skilled or intermediate care, day care services,

or foster home care) the amount of any social security cash benefits payable would be reduced to one-third of the regular benefit amount.

(2) For persons in a skilled or intermediate care facility, payments under the Supplemental Security Income (SSI) program would be reduced to a rate of $25 a month. If both husband and wife are in such a facility, the SSI payment would be reduced to a $50 monthly rate. (These provisions parallel the SSI provisions applicable to institutionalized persons under the present Medicaid assistance program.)

Administration

Each State would establish a long-term care agency which would designate service areas for community long-term care centers, assist in their establishment, certify the conditions for their participation, monitor their activities, and pay for their services under the prospective reimbursement system described later. The State agency must be approved by SSA to be eligible for Federal funds.

The community long-term care center would be a public or nonprofit organization certified by the State and supervised by a local governing board. At least one-quarter of the members of the local boards would be elected by persons eligible under the program and at least one-quarter appointed by locally elected government officials (and in total, at least one-half would be eligible persons). A community center would be required to have written policies and procedures, maintain medical records for persons receiving services, meet health and safety standards, and fulfill other requirements established by SSA regulations.

Provision of Services

The community long-term center would make known to the public the services it makes available and would provide these services directly or through arrangements with other providers or personnel. It would evaluate and certify the needs of eligible persons (considering their health status) for the various covered long-term services and maintain a continuous relationship with the patients to assure that appropriate services are being given, and changes in needs are considered. It must provide an opportunity for the patient and his family to participate in these decisions. The center could not certify inpatient institutional services unless it determines a person's needs could not be met through covered outpatient services or other community resources.

Persons dissatisfied with determinations concerning their eligibility and benefits under this program would be entitled to hearings and appeals by the SSA, and judicial review of SSA determinations, on the same basis as for other benefits under the social security program.

Reimbursement

The State long-term care agency would reimburse the community long-term care centers using prospective reimbursement methods approved by SSA, as described later for other providers of service. Also, a particular State could propose its own additional methods of prospective reimbursement and these proposed methods would be reviewed by the SSA and approved, if the SSA determined that they would not increase costs (as compared to other approved methods). Each long-term care center would elect its reimbursement method from among the national or Statewide methods available to it.

Financing

Persons enrolling in the program would pay a premium of $6 monthly.

The SSA would reimburse States with approved State agencies 90 percent of the amount spent by the community long-term care centers. In addition, it would pay 60 percent of the administrative costs of the State long-term care agency.

For the first 3 years of the program, the States would pay the SSA an amount equal to 50 percent, 30 percent, and 10 percent, respectively, of their 1973 spending for skilled and intermediate care facilities under their Medicaid assistance programs.

The Federal Government could deduct the premium due from enrollees from payments due beneficiaries under the social security, SSI, railroad retirement, or Federal civil service retirement and disability programs. The enrollee could also pay the premium directly to the SSA.

A separate Federal long-term care trust fund would be established to receive the income and pay the benefits of the long-term program. It would be managed by a board of trustees in a manner similar to the other Medicare trust funds.

ADMINISTRATION AND REGULATION OF THE PROGRAM

Unless otherwise indicated, the provisions described in this section on administration and regulation apply to both the proposed new national health insurance and the revised Medicare programs.

Administration

The bill states that in creating the contributory social security benefit and health insurance programs, the Government has assumed the obligation to honor these earned rights, assure the long range fiscal integrity of the programs financed by income dedicated to the programs, and provide for nonpolitical, objective, and skilled program administration.

Under present law, the SSA is a component agency of the Department of Health, Education, and Welfare (DHEW) with the duties of administering certain programs delegated to it by the Department. The bill establishes an independent SSA headed by a 3-man board (with one member designated chairman) appointed by the President with the advice and consent of the Senate. The board members, only two of which may belong to any one political party, would serve 5-year terms. The board would appoint an executive director and a general counsel. (The present position of the Commissioner of SSA would be eliminated.)

The independent SSA would administer the old-age, survivor and disability insurance (OASDI) program, including the black lung program, SSI, Medicare, and the proposed new national health insurance program. All functions of the DHEW with regard to these programs would be transferred to the SSA, including the requirement to study and recommend methods of improving economic security.

Advisory Council

A national health insurance advisory council would be established. Its 19 members, serving 4-year terms, would include persons outstanding in the field of medical care, including representatives of organizations of medical professional personnel and of the general public.

Drug Formulary Committee

As mentioned earlier, a national health insurance formulary committee would compile and publish the health insurance drug formulary (the list of drugs covered by the program). The committee would be composed of the Commissioner of Food and Drugs and four other persons of professional standing in medicine, pharmacology or pharmacy, appointed by the SSA. These four members, who cannot be Federal employees or have any interest in the composition of the formulary, would elect one of themselves as chairman.

The committee would have full access to information on drug products from all Federal agencies and could request information from drug manufacturers, suppliers, and other persons.

A manufacturer of a drug product not included in the formulary could petition the committee for its inclusion, and if denied, would be entitled to a hearing before the committee. Similar procedures would apply to drugs, previously included in the formulary, which the committee has decided to remove.

Separate Budget

Under present law, all financial transactions of the Federal Government are presented in the Federal unified budget. The bill would separate the trust funds of the programs of the independent SSA from the general fund of the Treasury (commonly known as the administrative budget).

Freedom of Choice

The bill states an intent that the administration of the program not interfere with the freedom of physicians and patients to choose where and how they will give or receive medical care. It states that the government would not be permitted to make medical judgments, but only physicians could do so. The SSA is forbidden to own or operate any elements of the health care system.

Relationship to Other Government Programs

As indicated, the Medicare program for the aged and disabled would be revised and would continue to operate. The Federal Medicaid assistance law would be repealed. Other Federal medical programs including those of the Veterans Administration, Indian Health Service, and the CHAMPUS program for military dependents would continue, as would Federal and State workmen's compensation programs.

Reimbursement of Providers of Service

Institutional providers of service--hospitals, SNF's, home health agencies, neighborhood health centers, community mental health centers, and HMO's--would be reimbursed on a prospective reimbursement basis.

Prospective reimbursement methods would be established by the SSA, after consultation with interested groups. Various methods of reimbursement could be made available to all providers and additional methods in specific regions or States. The SSA must give 60 days notice concerning a proposed method to the House Ways and Means Committee and the Senate Finance Committee, before final issuance of the method.

Providers would select a reimbursement method for the coming year from the approved national, regional, or Statewide methods available to them. Their selection must be approved by SSA. Once approved, the prospectively determined amount of payment under the agreed method may not be changed for the year, except in case of natural catastrophe or unexpected changes in demand or patient case mix not under control of the provider, as indicated in regulations. A provider could appeal an SSA decision regarding exceptions to the Provider Reimbursement Review Board (established by P.L. 92-603 and incorporated into the proposed program).

The SSA could withdraw a reimbursement method if an insufficient number of providers elect it or the method does not achieve improved results.

Criteria for Prospective Payment Methods

Prospective payment methods offered by the SSA would need to meet the following standards and criteria:

(1) The method would be designed to (a) provide financial incentives for efficiency of operations equal to the potential difference between the prospective rate and actual costs, (b) assure providers that their total income will equal their financial requirements, (c) include the participation of the provider in implementing the method, (d) assure high quality services to patients, and (e) maintain independent management, discretion, and responsibility on the part of the provider.

(2) The rate of payment would recognize the provider's total cost of operation, including costs attributable to approved capital expenditures, costs of approved working capital, and costs due to bad debts.

(3) The payment rate would provide a reasonable return on invested equity capital, based on rates of return on investments of comparable risk, for for-profit providers. Nonprofit providers could also be paid a return on capital to recognize the risks assumed under prospective payment methods.

Providers could also receive a quality management payment of 50 percent of the difference between its rate of increase in costs in a year and the increase in the "class average rate." The class average rate represents the average increase in costs for the 3 previous years for all providers in the same class group (according to a method of grouping of similar providers to be developed by SSA). A provider

receiving a quality management payment would be required to pay at least one-half of the payment to their employees and medical staff, under a plan approved by its governing board.

If the provider's increase in costs exceed the class average rate, 50 percent of the difference would be added to its increase in costs in the next year before computing any possible entitlement to a quality management payment for that year.

Physicians and Other Health Professionals

Payments to physicians and other health professionals would be based on a fee schedule for an area (contiguous with the PSRO area) proposed by the medical society or equivalent organization in the area. The schedule must be approved by the SSA. The SSA would be required to give approval if it determined that the average fee for the year would be no higher than that for 1973, after adjustment to reflect economic changes over the years as indicated by an appropriate economic index.

An approved schedule would ordinarily be in effect for a 1-year period, but the medical society or organization could propose a new schedule at any time. The new proposal would be evaluated by SSA on the same basis as described above. If no schedule is proposed, or the proposed schedule is not approved, one would be established by the SSA based on a previous schedule for the area or one for a similar area.

Physicians and other professionals could elect as participating or nonparticipating practitioners. Those participating would agree to accept the fee schedule amount as full payment for their services and be paid the scheduled amount for a service including the deductibles and coinsurance due from the patient (under the health care reimbursement system described later). Further, they could file with the carrier a single consolidated bill for all covered services for a period and receive a single check (rather than billing separately for each patient, as under present Medicare).

Nonparticipating practitioners could charge patients more than the fee schedule amount. They would receive the fee schedule amount from the carrier and would need to collect all of the cost sharing as well as the additional fee from the patient. They could not use the consolidated billing procedures.

A fee schedule in effect in an area and the names of participating practitioners would be made available to the public.

Outpatient Drugs

Outpatient drugs would be paid according to a reasonable allowance, based on the cost of the drug to the pharmacy or other final dispenser (referred to as the acquisition cost) and a dispensing fee. The determination of acquisition costs would recognize differences in prices among regions and among various classes of dispensers. Where the prices vary significantly, an average price by region and class of dispenser could be set by SSA. Differences in price among named drugs would be recognized, but any named drug whose price exceeds 150 percent of the average price of the same drug would not be covered under the program.

Participating pharmacies and other dispensers would file with SSA the amount of their dispensing fee for the first year of the program, without limit on the amount. These filed fees would become the basis for reimbursement, except that no fee could exceed the 90th percentile of the distribution of the fees filed in the locality. For later years, the dispensing fee allowance would be increased by SSA on the basis of an appropriate economic index data. No dispensing fee would be paid to institutional providers or to physicians who dispense drugs (even to physicians who qualify as a "participating pharmacy" as described later).

Special provision would apply to insulin products for which the reimbursement amount could be determined by SSA.

Other Medical Services and Supplies

The charges for other kinds of medical services, supplies, and equipment could not exceed the lowest charge levels at which they are widely and consistently available in the locality.

Reimbursement System

Persons covered by the program would be issued a health card, to identify them as enrolled, and a health card account would be established for each enrollee. These accounts, similar to accounts maintained by credit card organizations, would serve as the vehicle for payments from intermediaries, carriers, and other sources for reimbursement to participating providers of service (including all institutional providers, participating pharmacies, and physicians and other professionals who have elected to participate as described earlier).

The health card account would pay the provider the full rate for their service, including the cost sharing due from the patient. The account would collect the cost sharing from the patient, who could pay on credit over a period and at interest rates indicated by SSA regulations.

Payment would not be made on this basis, however, if an account is in default. An account would be in default if it is 90 days in arrears (that is, the last payment due has not been made for at least 90 days) and the patient has not made special arrangements to pay, or shown any indication of intent to pay in a reasonable period. If an account is in default, the provider would need to collect the cost sharing from the patient.

The SSA would be responsible for the operation of the health card system and the collection of cost sharing payments due from the patient. At its option, SSA could arrange for the function to be performed by a consortium of carriers. These carriers would need to be ones already under contract to administer payment of noninstitutional benefits, as described below.

Administration of Payments Through Intermediaries and Carriers

Intermediaries and carriers would be used to administer payment of benefits in a manner similar to the present Medicare program. As under Medicare's hospital insurance program, institutional providers could elect to receive payment through a public or private organization which is under contract with SSA, called an intermediary, or may deal directly with SSA. (Most hospitals have elected Blue Cross plans as intermediaries.)

Under Medicare's supplementary medical insurance program, payments to physicians and others are administered through carriers, under contract with SSA, operating in assigned geographical areas. The proposal would continue these provisions but would require that (unlike Medicare) the contracts between SSA and carriers be subject to the competitive bidding procedures generally applicable to contracts under Federal law (Section 3709 of the Revised Statutes). Also, to be qualified, a carrier must have written at least 3 percent of the dollar value of health insurance in the United States in 1973, and must demonstrate that it is capable of efficient and effective claims operation.

Various types of organizations, including voluntary associations, corporations, and parternships could qualify as carriers. The organization could be one which pays for or provides health services under group insurance policies, hospital or medical service agreements, or membership or subscription contracts. The SSA would establish and publish a list of all qualified carriers in the United States.

The proposal would permit an employer with at least 1,000 employees to select any qualified carrier under contract with SSA, in lieu of the assigned carrier in the area.

Participation and Regulation of Providers of Service

In general, the proposal incorporates the requirement and standards for participation of providers of service of the Medicare program (these standards are shown beginning on page 225) including the applicable amendments to Medicare under P.L. 92-603 (H.R. 1).

As under Medicare, State health departments under contract with SSA would be responsible for determining compliance with the conditions for participation for institutional providers of service.

Additional Standards

Reflecting the additional benefits of the proposal, provision is made for expanded participation of optometrists and dentists who must be legally authorized to practice in their State. Chiropractors services are excluded from the new national health insurance program.

The additional standards also require that hearing aids only would be covered when authorized by a prescription written by a physician. Kidney dialysis and transplants are covered only if furnished in a facility meeting requirements established by regulation.

Services of a physician or other practitioner performed in a nonparticipating hospital would not be covered services under the program.

Participating Pharmacies

Drugs would be covered only when dispensed by participating pharmacies. They would be required to be licensed under State law, submit bill as prescribed by regulation, accept payment as described above, and comply with other provisions of the proposal. By regulations, a physician could be considered a qualified participating pharmacy in areas where no other pharmacists are available and when dispensing drugs in an emergency.

Physicians' Extenders

The bill also provides for participation of physicians' extenders--including physicians assistants, nurse practitioners, and similar personnel--who meet the following standards:

(1) They must perform services under the supervision and control of a physician, or act as his agent, and these services must be related to the supervising physician's type of practice.

(2) They must complete a training program, or pass a certification examination of an appropriate organization, or meet certain proficiency requirements--in all cases as approved under regulations.

(3) The charges for their services must be included in the bills of the supervising physician or employing organization.

(4) The performance of their services must be legal under State law.

Utilization Review

The proposal incorporates the provisions of P.L. 92-603 establishing the Professional Standards Review Organization (PSRO) to review the necessity and quality of inpatient services under Medicare and Medicaid, and extends these provisions to all inpatient and outpatient services covered under the proposed program. It also includes the P.L. 92-603 requirements for pre-admission review for skilled nursing care and home health services, as well as the general Medicare requirements for certification of the necessity of services and utilization review by the staff of institutional providers.

Surgery and Specialized Procedures

Major surgery and other specialized services designated in regulations would be covered only when furnished on referral by a physician in general or family practice and only when performed by a specialist.

Also, for specified types of surgery, also indicated in regulations, prior consultation and approval by another qualified specialist would be required. For these specified types of surgery, regulations could also require that a pathology report and clinical abstract or discharge report be submitted to the carrier with the claim for payment. If the surgery is not approved under these provisions, the cost of the hospital and other services incident to the surgery would also not be covered. The provisions described above would not apply in case of emergency services (except for the requirement for a clinical report).

For these requirements, a physician would be considered a specialist if he is (1) board certified or board eligible, (2) authorized by SSA on the basis that he has experience in the speciality, meets specified SSA standards and, where appropriate, is recommended by a participating hospital, or (3) authorized by SSA because there is a shortage of these specialists in an area.

Control of Services, Facilities, and Capital Expenditures

The prospective payment method for institutional providers would not include payment for existing or proposed services or facilities of providers unless approved by the State and area planning agencies. The SSA could overrule the action of the State planning agency if it determined the agency's decision was arbitrary or capricious (or the agency took no action on a provider's proposal for more than 60 days, or did not afford the provider an opportunity for a hearing).

Further, no additional substantial capital expenditures may be made by providers unless approved in writing by the State and area planning agencies. Facilities obtained under lease arrangements would be subject to the same provisions. (The definition of substantial capital expenditure is the same as under P.L. 92-603.) The planning agencies determinations would be subject to review by the SSA whose decision would be final (and notsubject to administrative or judicial review).

Supplemental Private Health Insurance Certification

The proposal includes certification provisions designed to encourage the availability of adequate supplemental private health insurance coverage. Under these provisions, private health insurance carriers could voluntarily submit health insurance policies meeting certain minimum requirements to the SSA for consideration as a certified policy. The SSA would certify qualified policies. It would designate an emblem and this emblem and other indications of certification could be used by the carrier in advertising certified policies to the public.

If the certified policy is a group policy, the carrier must also make available an equivalent nongroup (individual) policy in the same geographic area.

Requirement for Certification

A certified family health insurance policy must automatically extend coverage to newborn or adopted children. A group policy could not exclude payment for pre-existing medical conditions or require a waiting period before their coverage. Also, a policy covering an employment group must meet these additional requirements: (a) continue coverage for at least 31 days after termination of employment, (b) offer terminated employees a reasonable opportunity to obtain a certified nongroup policy, and (c) provide an annual open enrollment period of at least 31 days to permit enrollment of employees who failed to elect coverage previously.

A certified health insurance policy may exclude payment for services covered by the proposed health insurance program, by workmen's

compensation laws, and by programs where there is no legal obligation to pay (e.g., VA). It may exclude routine physical examinations and cosmetic surgery.

Benefit-Premium Ratios

Certified policies must meet standards concerning the ratio of the amount of benefits paid to the amount of premiums collected (similar to a retention ratio). In establishing the standards, the SSA would consider the profit or nonprofit nature of the carrier and the number of subscribers in a group. For individual (nongroup) policies, the ratio would be the same as that established for the smallest groups. In evaluating the ratio for a particular policy, consideration would be given to the average ratio for similar certified policies.

The Department would periodically review the benefit to premium experience of each certified policy to determine if the policy continues to meet these requirements for certification.

Group Practice Plans

The same requirements for certification would not apply to comprehensive prepaid group practice plans, but special standards would be developed that would, on an actuarial and benefit basis, be equivalent to the general requirements.

Report

Three years after these provisions become effective, the Department would report to the Congress on the availability of certified insurance, and the extent of coverage, in each State.

HEALTH RESOURCES DEVELOPMENT

The bill would establish a health resources development board in the DHEW with the function of assuring that health facilities and manpower, and methods of delivering health services, are adequate to provide the health benefits of the proposed program.

The board would consist of three members (with a maximum of two from any political party) appointed by the President with the advice and consent of the Senate, with one member designated as chairman. The board would be headed by an executive director and would be provided with its own staff (including a maximum of 100 positions in the professional, scientific, and executive services at grade levels 16 to 18 of the Federal General Schedule).

The board would report annually to the House Committee on Interstate and Foreign Commerce and the Senate Committee of Labor and Public Welfare including (1) before the start of the program, an evaluation of health resources needed to provide benefits and (2) after the start of the program, evaluation of the adequacy of health resources and the effectiveness of measures undertaken to improve the delivery of health services.

A national health insurance resources advisory council would advise the board on general policy. It would also recommend to the board and the Congress proposed revisions in administration and legislation concerning resource development and the operation of the new health insurance program. The council would consist of the chairmen of the social security and health resources development boards and 20 other members representing providers of service and consumers, with the latter to constitute a majority. The members would be appointed for 4-year terms by DHEW, upon recommendation of the health resources board.

Studies and Research

The health resources development board would study the overall effect of the health delivery system under the new health insurance program on the health status of the people. It would also conduct studies on specific subjects, including national licensing of health professionals, medical record and retrieval systems, coordination of health services, methods of assessing the quality of health care, and comparisons of the quality of health care under different delivery and payment systems.

Health Planning

In consultation with State health planning agencies, the board would promote and support health planning on an area and State basis. It would periodically review the activities of the State planning agencies. If a State agency was not carrying out its responsibilities, the board could assume these functions for that State.

Grants and Loans

The provisions of the bill authorizing financial assistance for resource development place priority on improving services on an ambulatory basis provided as part of a system of comprehensive care. Decisions of the resources board would be guided by the recommendations of State and local planning agencies. Financial aid would be available to the following types of organizations.

(1) Health maintenance organizations qualified under the Health Maintenance Organization Act of 1973.

(2) Public or nonprofit organizations which provide all the services covered under the proposal. However, they may exclude institutional, mental health, and dental service and furnish these services under arrangements with either providers.

(3) Public or nonprofit primary care centers (including satellite centers established by hospitals) which furnish physician, nurse, supporting personnel and basic laboratory services, and make arrangements to provide all other covered services.

(4) Nonprofit organizations furnishing comprehensive dental services, to be further defined by regulations.

The qualified organizations described above could receive financial assistance, as follows:

(1) Grants of up to 90 percent of the costs of developing a new organization, and 80 percent of costs of expansion of an existing organization, but excluding any costs for construction.

(2) Loans for construction of facilities up to 90 percent of costs for a new organization and 80 percent of costs for an existing organization.

In addition, by contract with the health resources board, the operating deficit of newly established or enlarged organizations could be paid for as long as 3 years, if the organization is making progress toward self-support.

Manpower Training

After consulting with the State planning agencies, the board would establish priorities for education and training of health manpower. Funds for this training could be provided by contracts with educational or other organizations. Also, stipends could be paid directly to students in amounts not exceeding those payable under comparable Federal programs. Funds are authorized for training or retraining of personnel as follows:

(1) Training of medical students for general or family practice, or for specialties in critical shortage.

(2) Training for professional and paramedical occupations, if other Federal financial assistance is not adqequate.

(3) Training for the development of new kinds of health personnel, especially those useful in providing comprehensive care. Under this provision, grants could also be made to study the usefulness of the new occupations.

The board would also have general authority to train and recruit professionals who agree to practice in urban or rural areas of acute shortage, or in the four types of organizations eligible for financial assistance described above, and to pay these practitioners a stipend to supplement their professional earnings for up to 5 years (and for an additional period where appropriate).

Financing

The bill authorizes appropriations for the health resources development board of $400 million and $600 million, respectively, for the 2 years before the start of the program. In the first year of the program, the board would receive 2 percent of the income of the national health insurance trust fund, in the second year 1-1/2 percent, and in years thereafter, 1 percent.

Other Federal Assistance

The bill would require that financial assistance under the proposed program could not be used to replace funds available under other Federal programs and directs the Executive Branch of the Government to use these funds to further the objectives of the national program. The health resources development board could loan 90 percent of the non-Federal share (that is, the share which the sponsor of a project ordinarily contributes) required under another government program. Also, where a loan has been obtained under another Federal program, the fund could pay the interest on the loan that exceeds 3 percent.

FULTON-BROYHILL--HARTKE BILL

The "Health Care Insurance Act of 1973" was introduced by Representatives Richard H. Fulton of Tennessee and Joel T. Broyhill of Virginia as H.R. 2222 and by Senator Vance Hartke of Indiana as S. 444. The bill, referred to as the Medicredit proposal, is endorsed by the American Medical Association.

General Concept and Approach

The Medicredit proposal would provide tax credits against individual income taxes to offset, in whole or in part, the premium cost of qualified private health insurance policies. A qualified policy must provide specified basic and catastrophic benefits and the maximum amount of the tax credit would be based on the premium cost of this policy. The amount of the credit for a family would be graduated on the basis of the family's income tax liability (the amount of tax payable for the year) with the larger credits available to lower income groups. Families with little or no tax liability would receive a payment voucher for purchase of the insurance. All persons could voluntarily elect coverage under the plan, except those age 65 and over.

Coverage of the Population

Since all families and individuals potentially subject to the Federal individual income tax would be eligible, virtually the entire population could voluntarily elect coverage under the plan. However, persons age 65 and over (who would remain under the Medicare program) would not be covered by the proposal.

Benefit Structure

The amount of the tax credit would be based on the premium cost of a qualified policy which provides specified basic and catastrophic benefits. For the catastrophic benefits, the amount of tax credit would be equal to the full premium cost applicable to those benefits. For the basic benefits (which constitute the major part of the benefit package) the amount of the credit would be equal to the premium for persons with no tax liability, and would be slowly graduated downward (for each $10 increase in tax liability) with a credit of 10 percent available to those with taxes of $891 or more.

This schedule of credits is applicable to all types of returns including individual returns and joint returns of married couples. In computing the amount of tax liability for Medicredit purposes, the taxes

of dependents would be included (even though the dependent files an individual return). Also, the tax liability of a husband and wife filing separate returns would be combined.

The following tabulation shows the percentage of the premium cost of the basic benefits that could be taken as a credit at selected levels of tax liability, as shown in the Medicredit bill. Also a column has been added showing the equivalent adjusted gross income, for a family of four taking the standard deduction, at specified tax liability levels (for 1973 when the Tax Reform Act of 1969 became fully effective).

Amount of tax liability	Amount of adjusted gross income	Amount of tax credit (percent)
None	$4,300 or less	100
$100	$5,000	90
$300	$6,350	70
$500	$7,600	50
$700	$8,750	30
$891	$9,950 or more	10

Individuals or families with no tax liability would receive a voucher certificate which would be accepted by a carrier for the purchase of a qualified insurance policy. Those with a tax liability less than the amount of the credit could receive a certificate, or claim the additional credit like an overpayment of taxes.

Taxpayers who elect a tax credit could not claim the health insurance premium as a medical expense deduction for income tax purposes.

Employer-Employee Plans

Under present law, an employer may take the full cost of his premium contributions for health insurance for his employees as a business deduction. Under the proposal, he must maintain a qualified plan (providing the specified benefits) to continue to take a full deduction; otherwise, only one-half the contributions could be taken.

The employee, in computing the amount of premiums against which he may take a tax credit on his personal tax return, would count 80 percent of the employer contribution to a qualified plan as if it were his own contribution.

Qualified Insurance Policy

As indicated, a qualified policy under the plan would offer specified basic benefits and catastrophic benefits. The policy would need to be

guaranteed renewable and benefits could not be refused because of pre-existing medical conditions. The benefits of the policy are shown in table 1.

General dental care would initially be limited to children age 2-6 and would be extended each year to children 1 year older, up to age 17. (For example, in second year to age 7, in third to age 8.) Emergency dental services and certain oral surgery (similar to the Medicare oral surgery benefit) would be provided at the start of the program without age limitations. The physicians and outpatient service benefits includes unlimited physical examinations, innoculations, well-baby care, and psychiatric care.

The family's total payment for coinsurance under the basic coverage for physicians', laboratory, and X-ray services combined would be limited to $100 annually (20 percent of the first $500). An additional limit of $100 annually would apply to hospital outpatient, home health and ambulance services combined, and a separate $100 limit for dental care.

Benefits under the catastrophic coverage (which applies to additional hospital days, prosthetics and blood) would first become payable after a corridor deductible (out-of-pocket payment) which would vary according to family income. Cost sharing payments made under the basic plan would be creditable toward meeting this corridor deductible. The deductible, which would be based on the family's taxable income (after exemptions and deductions) including the income of dependents, would be equal to 10 percent of taxable income.

Administration

Persons would purchase qualified health insurance from private health insurance carriers who would issue policies, collect premiums (or vouchers), and process claims for benefits.

State insurance departments would determine whether insurance carriers and policies are qualified under the Medicredit program. Carriers would be required to participate in assigned-risk pools and accept the poor risks assigned them by the State insurance departments.

The Department of Health, Education, and Welfare would issue and redeem the health insurance voucher certificates. Also at the national level, a health insurance advisory board would be established, consisting of the Secretary of Health, Education, and Welfare (chairman), the Commissioner of Internal Revenue, and nine additional members (the majority of whom would be physicians) appointed by the President with Senate approval. The board would establish the regulations for the administration of the program and issue the Federal standards to be

TABLE 1.--FULTON-BROYHILL--HARTKE BILL: Benefit provisions under a qualified insurance policy 1/

Type of service	Basic benefits	Catastrophic benefits 2/
Institutional services:		
Hospital inpatient care.	60 days a year with a $50 deductible for each stay.3/	Unlimited additional hospital days.
Skilled nursing.....	2 days in a skilled nursing facility may be substituted for 1 day of hospital care, with a $50 deductible for each stay.	30 additional days.
Personal services:		
Physicians' services ..	No limit. (20% coinsurance, with a limit per family of $100 a year.)	4/
Laboratory and X-ray ..		
Hospital outpatient care	No limit. (20% coinsurance, with a limit per family of $100 a year.)	4/
Home health services....		
Ambulance service.....		
Dental services.....	As specified.5/ (20% coinsurance, with a limit per family of $100 a year.)	4/
Other services and supplies:		
Medical appliances.....	---	Prosthetic devices.
Blood.....	---	Outpatient blood and plasma (after the first 3 pints.)

1/ For persons on Federal cash assistance, any deductibles and coinsurance would be met by the State under Medicaid.

2/ Payable after family meets a secondary deductible of 10% of the family's taxable income reduced by the amount of copayments made by that family for covered basic benefits.

3/ Includes inpatient blood and plasma (after the first 3 pints).

4/ Services are provided under basic coverage without limit.

5/ General dental care for children; emergency dental care and oral surgery for all persons (see text).

used by the State insurance departments in determining whether insurance carriers and policies are qualified. In consultation with carriers, providers, and consumers, it would study methods to maintain the quality of care and the effective use of resources through utilization and peer review.

Relationship to Other Government Programs

The bill provides that benefits claimed under Medicredit may not be duplicated under other programs financed by the Federal Government. The Medicredit proposal would affect the Medicaid and other assistance programs by covering those services for the low-income population that were provided by the assistance programs.

Financing

The Medicredit program would be financed from Federal general revenues. The granting of tax credits would result in a reduction in Federal income tax receipts and the voucher certificates would be redeemed from general revenues through a special trust fund created for this purpose.

Standards and Reimbursement of Providers of Services

The bill includes a clause which prohibits Federal supervision and control over the practice of medicine, the manner in which services are provided, the selection or compensation of providers of services, or the operations of providers of services.

The insurance carriers participating in the program would reimburse the providers of services. The bill requires that payment for services under the program must be on the basis of usual and customary charges.

Delivery and Resources

There are no specific provisions regarding these subjects.

ASHBROOK BILL

The "Health Care Insurance Act of 1973" was introduced by Representative John M. Ashbrook of Ohio as H.R. 288. It is identical to H.R. 4960 introduced by Representatives Richard H. Fulton and Joel T. Broyhill in the 92d Congress. Representatives Fulton and Broyhill have introduced a revised bill, H.R. 2222, supported by the American Medical Association, discussed previously.

The major revision in the current Fulton-Broyhill bill (which distinguishes it from the old Fulton-Broyhill bill and the current Ashbrook bill) are as follows:

(1) Additional medical services are added to the basic benefits including home health care and certain dental care services, all subject to a 20-percent coinsurance. Routine dental care would initially be limited to children age 2-6 and would be extended each year to children 1 year older, up to age 17. Emergency dental services and certain oral surgery (similar to the Medicare oral surgery benefit) would be provided at the start of the program without age limitations.

(2) Total coinsurance payments by the family would be limited to $100 annually (20 percent of the first $500 of expenses) for hospital outpatient, home health and ambulance services combined, and a separate similar $100 limit would apply to dental care. (The separate limitation of $100 for physicians, laboratory and X-ray has been retained.)

(3) The formula for determining the "corridor deductible" after which catastrophic benefits become payable would be based on 10 percent of the family's taxable income. The previous formula was based on varying percentages applicable to specified income intervals.

BROCK BILL

The "Medical Expense Tax Credit Act" was introduced by Senator William E. Brock, III of Tennessee as S. 3670.

General Concept and Approach

The proposal would provide tax credits against personal income taxes when medical expenses exceed a specified percent of family income. The tax credit would ordinarily be claimed on the regular income tax return.

Coverage of the Population

All individuals and families potentially subject to the income tax, or virtually the entire population, could file for tax credits under the proposal.

Benefit Structure

A credit against personal income taxes would be allowed if medical expenses of the family members included on the tax return exceeded 15 percent of modified adjusted gross income. (Adjusted gross income would be modified by reducing it by the personal exemption of $750 for each family member and making other modifications described later.) The amount of the credit would be 85 percent of the medical expenses which exceed the 15 percent of income. Thus the proposal in effect incorporates an income-related deductible and a constant coinsurance rate.

For example, for a family of four with adjusted gross income of $9,000 ($6,000 after personal exemptions of $750 each) and medical expenses of $2,000 the tax credit would be calculated as follows:

Medical expenses	$2,000
15% of modified family income (of $6,000)	900
Difference	$1,100
Tax credit (85% of $1,100)	$935

Adjusted gross income would be modified (in addition to deducting personal exemptions) by adding the capital gains and interest on those government bonds which are excluded from adjusted gross income under present tax law.

The medical expenses included for the tax credit would be out-of-pocket expenses paid or incurred and the definition of medical expenses would be the same as for medical deductions under the present income tax law. However

the limitations on the deduction of health insurance premiums, to a maximum of $150, and the special limitations on deductions of drugs and medicines under present law would be removed for tax credit purposes. The supplementary medical insurance premium under Medicare would be considered as health insurance premiums.

Administration

Persons would be required to file an income tax return to claim a credit. The full amount of the credit will always be payable, without regard to the amount (if any) of taxes. Procedurally, the credit would be applied against current-year taxes and then against the preceding year, but the full credit would be given upon filing. (In this way, the proposal is similar to some negative income tax proposals.)

Relationship to Other Government Programs

The President would be authorized to study the adequacy of the tax credit proposal in meeting the health needs of the Nation and to recommend whether Medicare, Medicaid, and other Federal medical assistance and health care programs should be terminated, reduced, or changed.

Financing

The proposal would be financed from Federal general revenues. The bill repeals the present medical expense deduction provisions of the income tax law.

Other Provisions

The bill includes no special provisions concerning standards for providers, reimbursement, or health delivery and resources.

ROE-BEALL BILL

The "National Catastrophic Illness Protection Act of 1973" was introduced by Representative Robert A. Roe of New Jersey as H.R. 1054 and Senator J. Glenn Beall, Jr. of Maryland as S. 587. It is identical to a bill introduced first in the 92d Congress by Representative Lawrence J. Hogan of Maryland.

General Concept and Approach

The proposal would establish a program of private health insurance protection against the cost of catastrophic illness. Persons could voluntarily buy private insurance policies that would pay for medical expenses which exceed a specified amount, with the amount depending on family income and size. The program would be administered by private insurance carriers under State supervision. The premium would be paid by the policyholder, but the Federal Government could subsidize the premium, using funds from general revenues. The Federal Government would also administer a reinsurance plan for insurance carriers under the plan.

Coverage of the Population

All persons could obtain coverage on a voluntary basis.

Benefit Structure

For the purpose of this program, any services defined as medical care under the present Federal income tax law relating to medical expense deductions could be included in a State plan.

The policies would pay the medical expenses of individuals and families whose expenses exceed a specified amount (referred to as the annual deductible). This deductible would vary according to family income and number of dependents. For low-income people no annual deductible would be applicable (and thus the plan would pay for all covered medical expenses) but the deductible would rise rapidly as family income increased.

The amount of the deductible would be based on the family's "adjusted income," which is the "adjusted gross income" shown on the Federal income tax return reduced by the total amount of personal exemptions. In calculating the deductible, the first $1,000 of "adjusted income" would be disregarded and the deductible would be equal to (1) 50 percent of adjusted income between $1,000

and $2,000, plus (2) 100 percent of adjusted income over $2,000. An illustrative schedule based on this formula for a family of four appears below:

Adjusted gross income	Adjusted income 1/	Annual deductible
$1,000.....	None	None
$4,000.....	$1,000	None
$5,000.....	2,000	$500
$7,500.....	4,500	3,000
$10,000.....	7,000	5,500
$20,000.....	17,000	15,500
$30,000.....	27,000	25,500

1/ Based on personal exemption of $750 per person, which would become effective for 1973 returns.

In figuring the family's medical expenses, medical costs paid in a year for continuous, uninterrupted care which began in an earlier year would be considered to have been paid in the earlier year.

All medical expenses incurred would count toward meeting the deductible including expenses paid by other private insurance or covered by Medicare, Medicaid, or other public programs.

Administration

Each State would design its own health insurance plan under regulations of the Department of Health, Education, and Welfare. The State insurance department would make arrangements with, and supervise, private health insurance carriers who would sell the insurance, collect premiums, and administer claims.

A carrier organization would be established in each State that would attempt to distribute the risks equitably among the insurers and would obtain coverage, through assigned risk pools, for persons unable to obtain coverage at the regular premium rate.

The Department of Health, Education, and Welfare could administer a plan in any State that has not established one.

Relationship to Other Government Programs

Medicaid and other assistance programs would be affected because they would not make payment for the services covered by the insurance. Most other Government programs would not be affected.

Financing

Periodically, the Department of Health, Education, and Welfare would determine the actuarial value, according to family size and composition, of the catastrophic insurance policy in each State. The Department would then establish a premium rate which could be lower than the actuarial value, if the Department believed that a lower rate was desirable in order to obtain more widespread coverage. The Federal Government would pay the insurance carrier the difference between the actuarial value and the established premium. These payments, referred to as premium equalization payments, would be paid from Federal general revenues through a national catastrophic illness fund.

The Department would also arrange for reinsurance for carriers who have incurred extraordinary losses in connection with the catastrophic insurance. The premiums for this reinsurance would be paid by participating carriers as determined by the Department. This reinsurance plan would also be administered through the national catastrophic illness fund and the Department could contract with private firms to handle the reinsurance claims.

Other

There are no provisions in the bill concerning standards for providers of service, reimbursement of providers, or health care delivery and resources.

SAYLOR BILL

The "National Health Care Program" was introduced by Representative John P. Saylor of Pennsylvania as H.R. 1916.

General Concept and Approach

The proposal would establish a two-part national health insurance program called the "National Health Care Program" and abolish the Medicaid program. All persons would be covered under one of the parts, depending on their annual income.

Part A of the proposal would provide the poor with basic coverage under private health insurance plans, as well as coverage of catastrophic health care costs. The program would be administered by the States, and financing would come from Federal and State general revenues.

Part B, a federally administered program, would insure the remaining population against catastrophic health care costs beyond a specified amount. It would be financed by a tax on wages, self-employment income, and other income of individuals.

PROVISIONS FOR THE MEDICALLY INDIGENT (PART A)

Coverage of the Population

All persons at or below a State level of medical indigence would be covered under this plan. Each State would determine the level of medical indigence for its residents, i.e., the level of income below which an individual or family cannot meet their normal health care costs.

Benefit Structure

The State would purchase a qualified private health insurance policy for eligible individuals and families. The bill does not specify the benefits that a qualified policy must include, but permits the inclusion, at the option of the State, of any services defined as medical care under the present income tax laws relating to medical expense deductions. (This definition encompasses a very broad range of health care services.) The value of the policy would be at least equal to the average annual cost of adequate health care

in that State. The State is also required to provide catastrophic coverage of all costs for health care beyond the limits of the basic insurance policy. There would be no cost sharing.

Administration

The program would be administered by the States under agreement with the Department of Health, Education, and Welfare. If a State refuses to enter into an agreement, or fails to comply with requirements of an agreement, the Federal Government would administer the program in the State. In either case, the health benefits plans would be operated and administered by private insurance carriers.

Relationship to Other Government Programs

The proposal would replace the current Medicaid program. No specific reference is made to other Government health programs, but the bill calls for a report on provisions of law which require modification or repeal.

Financing

The program would be financed by State and Federal revenues. The Federal Government would pay States 85 percent of the cost of premiums for the purchase of the basic insurance coverage. States would pay the balance of the cost of basic coverage and the entire cost of coverage for the catastrophic program.

If a State does not participate in the program, the Federal Government would pay the entire cost of both types of coverage, and would recover those amounts (that the States would otherwise have been required to pay) by withholding Federal funds otherwise payable to the States.

Delivery and Resources

There are no provisions directly affecting the organization and delivery of medical services.

CATASTROPHIC HEALTH INSURANCE FOR NON-INDIGENTS (PART B)

Coverage of the Population

All persons with incomes above the State-determined level of medical indigency would be eligible for coverage under this part.

Benefit Structure

A program of catastrophic health insurance would be established that would cover 90 percent of health care costs above a specified annual deductible. As for the plan for the medically indigent, benefits could include any services defined as medical care under the present income tax laws.

The deductible amount that would have to be met before payment could begin (which could include expenses that were already paid under private insurance or public programs) would consist of the larger of the following:

$5,000 for all persons or families under age 65, or
$1,000 for persons aged 65 or over, or
25 percent of individual or family gross income for the year.

Administration

The catastrophic program would be administered by the Department of Health, Education, and Welfare and would follow, to the extent possible, the same procedures and requirements used under Medicare.

Relationship to Other Government Programs

The bill calls for a report, as discussed above.

Financing

The plan would be financed by a special tax of 0.4 percent on the sum of an individual's wages, self-employment income, and other earned or unearned income over $2,000, up to the same maximum as under the social security law. Revenues would be placed in a Federal health care trust fund, managed by a board of trustees, from which all benefits and expenses would be paid.

Other

The bill provides that, to the extent feasible, the reimbursement standards and procedures under Medicare be utilized for the catastrophic health insurance program (Part B). The bill does not include specific provisions regarding the organization and delivery of health services.

LONG-RIBICOFF--WAGGONNER BILL

The "Catastrophic Health Insurance and Medical Assistant Reform Act" was introduced by Senators Russell B. Long of Louisiana and Abraham A. Ribicoff of Connecticut as S. 2513, and by Representative Joe D. Waggonner of Louisiana as H.R. 14079.

General Concept and Approach

The proposal is presented in three major parts. A catastrophic illness insurance plan would provide benefits for persons in the general population who have incurred unusually large hospital or medical expenses. The medical assistance plan would, in effect, provide basic and catastrophic benefits for low-income persons through a uniform national plan. These two plans would be administered through the mechanism of the present Medicare program and are designed to coordinate their benefits and other provisions.

The proposal also includes provisions for encouragement and certification of improved private health insurance, also coordinated with the two health plans.

CATASTROPHIC ILLNESS INSURANCE PROGRAM

The catastrophic plan, which would cover persons and their dependents insured or receiving benefits under social security, would provide catastrophic benefits to persons who have already incurred long hospital stays or large medical bills. The program would be administered through the Medicare program and financed by special payroll taxes.

Coverage of the Population

Persons who are fully or currently insured under the social security program 1/ or entitled to social security benefits would be eligible, as well as their spouses and dependent children. In addition, eligibility would be extended to additional persons (and their dependents) who have certain specified credits under social security, but not enough to meet the regular insured requirements.

1/ A person who has social security credit for at least 1-1/2 years of work within a 3-year period is currently insured. To be fully insured, a person needs at least 1 quarter of coverage for each calendar year elapsing after 1950 or, if later, after the year in which he attained age 21, up to the year he becomes entitled to benefits. A person who has 10 years of work is fully insured for life.

State and local governments would have an option to "buy" into the program and cover, as a group, all their employees and annuitants (if not covered by social security) under an agreement with the Federal Government. The State would reimburse the program for the cost of benefits and related administrative expenses for these persons. The regular payroll tax for catastrophic illness benefits (described later) would not apply to State and local government employment.

Benefit Structure

The catastrophic health insurance program would cover the same kinds of benefits as provided under the Medicare program, as follows:

Institutional Services

- Hospital services.
- Skilled nursing facility services.

Personal Services

- Physicians' services.
- Laboratory and X-ray services.
- Home health services.
- Outpatient physical therapy services.

Other Services and Supplies

- Medical supplies and appliances.
- Ambulance services.

Hospital inpatient care would be covered after the first 60 days of hospitalization during a year. Payment would begin with the 61st day of hospitalization, with no limit on the number of additional days. Days spent in a hospital in the last 3 months of a year (that are not covered days for that year) would be counted toward meeting the 60-day hospital deductible for the next year. As under the Medicare program, there would continue to be a lifetime limit of 190 days of care in psychiatric hospitals. Payment would be subject to the regular Medicare coinsurance rate.2/

2/ The coinsurance rate under the proposal is related to the Medicare inpatient hospital deductible which, effective January 1974, was $84. For hospital care, the coinsurance is one-quarter of the Medicare deductible ($21) per day and for skilled nursing care, one-eighth ($10.50). The amount of the Medicare deductible is changed in January of each year if the average per diem rate for inpatient hospital services rises.

For persons under Medicare, hospital stays covered both under the proposal and under the Medicare program--which provide 90 days in a spell of illness and an additional 60-day lifetime reserve--would be reimbursed under the catastrophic program.

Skilled nursing facility services following a hospital stay would be covered for 100 days in a spell of illness. Payment would be made only after the individual had met the 60-day hospital deductible and was covered for at least 1 hospital day under the catastrophic program. Payment would be subject to coinsurance of the same amount as under Medicare.3/

Physicians' services and the other types of personal and other medical services, described above, would be covered without limit (except that the Medicare limitation of $250 in a year on payment for outpatient psychiatric physicians' services in a year would be retained). Payment would be made after a family has incurred expenses of $2,000 in the year, referred to as the "medical deductible." Only expenses for these covered types of medical services would be counted toward the deductible. Medical expenses incurred in the last 3 months of the year (not covered for that year) would be counted toward meeting the deductible for the next year. Expenses covered under private or government health plans would count toward the $2,000 expense limit. Payment would be subject to 20-percent coinsurance, as under Medicare. (The medical deductible would have to be met separately from the hospital deductible.)

The $2,000 medical deductible would be adjusted each year, based on the physicians' fee component of the Consumer Price Index.

Total coinsurance payments for a person for all the hospital and medical services covered under the proposal would be limited to $1,000 in a year for an individual. After that, there would be no further payment by the patient.

Relationship to Other Government Programs

Since the program is based on the requirements and provisions of the Medicare law, its relationship to other Government programs would be essentially the same as the Medicare program. (See discussion of the Javits bill.)

Financing

The program would be financed, in a manner similar to Medicare, by a tax on wages and self-employment income now subject to social security taxes. The tax rates for employers, employees, and the self-employed would be 0.30 percent for the first 3 years of the program, 0.35 percent for the next 5 years, and 0.40 percent thereafter. A separate

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3/ *Ibid.*

catastrophic health insurance trust fund would be established to handle program receipts and expenditures.

Also, for the first 3 years of operation, appropriations to the trust fund would be authorized from Federal general revenues to provide an operating fund and a contingency reserve. The amount of these appropriations would be equal to one-half the estimated expenditures of the program for each of the 3 years. These appropriations would be repayable to the Treasury without interest.

MEDICAL ASSISTANCE PLAN FOR LOW-INCOME PEOPLE

The medical assistance plan is a plan for low-income and medically indigent persons. It would be administered through the Medicare program, but would provide broader benefits. It is designed to mesh with the catastrophic plan, as well as other public and private health plans. The proposal would be financed jointly from Federal and State general revenues.

Coverage

The benefits of the program would be available to citizens (and aliens admitted for permanent residence) whose annual family income is below the amounts specified below, without regard to their age, family status, employment, or State of residence.

Individual	$2,400
Family of two	3,600
Family of three	4,200
Family of four	4,800
Family of more than four	4,800 plus $400 for each additional member

The types of income counted for eligibility would include both earned and unearned income--including wages, self-employment income, support and maintenance, annuities, pensions, veterans payments, workmen's compensation, social security, and unemployment insurance. Also included are rents, dividends, alimony, inheritances, and life insurance payments exceeding $1,500. Excluded from consideration are small gifts and certain funds received for educational purposes (such as scholarships, loans, and fellowships).

By regulation, procedures may be established under which specified gross amounts of income from a trade, business, or farming may be considered sufficiently large to disqualify families even though their income technically falls within the limits. These procedures could be

similar to those under the present Supplemental Security Income (SSI) program for the aged, blind, and disabled.

In addition, families who meet all the requirements for eligibility under a State Medicaid program at the time the assistance plan started would automatically be eligible under the plan (assuming they met the citizenship or resident requirements) if their income was within 105 percent of the States' income requirements for Medicaid.

Spend-Down Provisions

Families with income higher than the specified amounts could still qualify for benefits under the "spend-down provision." Under this provision, the family's income for the purpose of eligibility is considered its actual income reduced by the amount of incurred medical expenses the family is legally obligated to pay out-of-pocket. (Thus a family of four with annual income of $5,000 would qualify after they incurred out-of-pocket medical expenses of $200.) These medical expenses could be expenses actually paid or the reasonable charge for the services, if not yet paid. The types of medical expenses considered for computing the spend-down include a broad range of services (such as dental care, prescribed drugs, and optometrist services) not included among the proposals' benefits. Eligibility under the spend-down provision may be determined on a prospective basis if the future income is determinable and a family member can be expected to need institutional care.

Determining Eligibility

Ordinarily, eligibility would be determined by the annual income for the past year, unless the amount of prospective income for the coming year would apparently be much greater or lesser than the past year's income. Eligibility would continue throughout the year unless the income increases more than 20 percent above the eligibility requirements. Provisions are also included to permit eligibility (and termination) during the year for families whose circumstances change.

Benefits

The benefits of the program, listed below, include all services under Medicare, but also several additional ones. There are no limitations on the amount of services or any cost sharing required, except as indicated.

Institutional Services

Inpatient hospital services: 60 days in benefit period.
Skilled nursing facilities.
Intermediate care facilities.

Personal Services

Physicians' services: $3 copayment for each of first 10 outpatient visits per family.
Laboratory and X-ray.
Home health services.
Prenatal and well-baby care.
Family planning, counseling, and supplies.
Periodic examinations: For children under age 18.
Outpatient physical therapy.
Immunizations and pap smears: By regulation.4/

Other Services and Supplies

Medical supplies and appliances.
Ambulance services.

Services in an intermediate care facility would be available to patients who do not require services in a hospital or skilled nursing facility, but who have a physical or mental condition which requires care (in addition to room and board) available only through institutional facilities.

Mental health care services provided in an accredited institution are included in the hospital inpatient benefit if the service constitutes active care and treatment. Mental care is also covered on an outpatient basis and the amount of these services is not limited if provided by an approved community mental health center. If provided otherwise (e.g., by a psychiatrist), it is limited to a maximum of 5 visits, but additional visits would be covered if approved by a professional review organization as being necessary to avoid institutional care or serious dysfunction. The outpatient mental health benefit also includes drugs (other drugs are not covered under the proposal) if the physician determines they are necessary to avoid institutional care. The covered drugs are only those included on a list which indicates the mental condition for which it is effective and the appropriate dosage.

Payment for Other Programs

Payment under the assistance plan would also be made on behalf of eligible persons in conjunction with the catastrophic program and the Medicare program, as follows:

4/ The bill also amends the Medicare law to add immunizations and pap smears to that program.

(a) payment of the coinsurance required under the catastrophic proposal,

(b) payment of full cost of benefits under the catastrophic proposal for persons not eligible under it, and

(c) payment of the supplementary health insurance (Part B) premium under Medicare.

Copayments

The $3 copayment requirement would apply to persons under the Medicare program only to the extent this amount is less than the regular cost sharing required under Medicare.

A special copayment requirement would also apply to individuals who are not a member of a family, after the 60th continuous day spent in a long-term facility. The amount of this copayment would be equal to the amount of the patient's monthly income, less $50. (A similar requirement would apply in a situation where all members of a family have a stay exceeding 60 days.)

Relationship to Other Government and Private Programs

The present Medicaid program would be abolished and replaced by the new program. The Medicare program would continue.

Payments under the proposal would, except where previously indicated, be secondary to all other government and private health care programs and plans. (It would be primary only where a State has established a program, with higher income limits than the proposal, designed to supplement it.) Thus, where a person has coverage under another public or private plan, the medical assistance plan would pay only for benefits (or any cost sharing) not covered by the other plan.

The bill states its intent that the proposal not be construed to preclude States from providing protection against health costs, or individuals from obtaining private health cost protection. Under penalty of law, the bill prohibits employers, who provide group health insurance for their employees, to exclude an employee because he is potentially eligible for benefits under the medical assistance proposal.

In the event a person was eligible for enrollment in a health insurance plan (for example, an employment-related group plan) under which the enrollees' contribution was 25 percent or less of the total premium, but did not enroll, benefits payable under the medical assistance plan would be reduced by $250 in a benefit period. A similar reduction would apply to aged persons who fail to enroll in the supplementary medical insurance (SMI) part of Medicare.

Financing

The program would be financed by Federal and State general revenues. The State share would be as follows: an amount equal to the State's present payments under the Medicaid program (1) for those types of services covered under the medical assistance proposal and (2) again, for services under the new medical assistance proposal, one-half the payments it would have made under Medicaid if its eligibility requirements were the same as the medical assistance requirements--which of course would be applicable only to States with less liberal requirements. (The State's contributions, based on its expenditures in the year before the new program began, would be a fixed amount and would not rise in future years.) The State's contribution would be reduced, however, by one-half its actual expenditures for types of services not covered by the proposal (but presently eligible for Federal grants under Medicaid).

The balance of the cost of the proposed program would be financed from Federal general revenues. All funds would be held in a special medical coverage trust fund.

PROVISIONS AFFECTING BOTH PLANS

Administration

Both programs would be administered through the administrative mechanisms of the Medicare program. Under Medicare, the Social Security Administration in the Department of Health, Education, and Welfare is responsible for general administration of the program. Private carriers under agreement with SSA act as fiscal intermediaries responsible for administration of claims and payments to providers of services. The bill includes a provision, relating to the medical assistance program, authorizing the consolidation of the activities of these carriers in areas with small populations if necessary to improve quality and efficiency.

As under Medicare, State agencies would be responsible for determining whether providers of services meet the conditions for participation under the two proposed programs.

Persons eligible under the proposed medical assistance could enroll in a health maintenance organization and receive their services from these organizations, on a basis similar to that authorized for Medicare beneficiaries under P.L. 92-603 (H.R. 1).

Standards for Providers of Service

The program would apply the same standards for providers of services as under the Medicare program. (See page 225.) For intermediate care

facilities (which are not covered under Medicare) the bill requires the facility to be licensed under State law and meet regulations (to be established) concerning proper provision of care and safety and sanitation; it specifically includes qualified Christian Science sanatoria and institutions on Indian reservations.

Reimbursement of Providers of Services

Providers of services under the catastrophic program would be reimbursed on the same basis as under the Medicare program. Under Medicare, hospitals, skilled nursing facilities, and home health agencies are reimbursed on the basis of the reasonable cost of services. Payments to physicians (and certain other providers) are determined on the basis of reasonable charges. In general, physicians may file and accept the Medicare payment as full payment (taking assignment). Alternatively, they may bill the patient, who files and receives the Medicare reasonable charge (which may be less, but not more, than the physicians' charge).

The bill specifies that for the medical assistance program the physician and other providers must accept the reasonable charge as full payment for services. This would also apply where the medical assistance payment is made to supplement a payment under another public or private insurance program. In this case, the reasonable charge for these services, as determined under the medical assistance plan, would be considered the full charge.

Of course, reimbursement under the catastrophic and medical assistance programs would be subject to the additional provisions relating to reimbursement under Medicare included in P.L. 92-603 (H.R. 1). This would include, for example, the limits on costs for institutional services recognized as reasonable ("cost ceilings"), limitations on payment for services in connection with disapproved capital expenditures, and limitations on payment where cost for an institution is less than its customary charges. The new limitations on increases in the amount of physicians' fees would also apply. It would of course also incorporate the health maintenance organization (HMO) provisions of H.R. 1 and the Professional Standards Review Organizations (PSRO) established to review the use and quality of services under Medicare and other programs under the social security law.

PRIVATE BASIC HEALTH INSURANCE CERTIFICATION

The purpose of this section is to encourage the availability of adequate and reasonably priced private health insurance policies. It would also facilitate the offering of these policies by pools of private carriers.

Certification

Private health insurance carriers would voluntarily submit health insurance policies to the Department of Health, Education, and Welfare for consideration as a certified policy. The policy must meet certain minimum requirements concerning coverage, benefits, and premium charges. Procedures are established for continuing review of these requirements and for reports by the carriers.

If a group health insurance policy is certified, the carrier must also make available, in the same geographic area, an equivalent nongroup (individual) policy.5/

The Department would designate an emblem indicating a policy has been certified. This emblem and other indications of certification could be used in advertising a policy to the public. Also, a carrier who offers certified insurance, and does so in each geographical area where it normally offers health insurance, would be given the status of an approved carrier. Beginning 3 years after the start of the program, only approved carriers could qualify as intermediaries or carriers under the Medicare program or the proposed medical assistance program.

Benefits

A certified policy must offer the following minimum benefits:

(a) Hospital inpatient benefits for at least 60 days of care, with a maximum deductible of $100, but with no further cost sharing.

(b) Medical coverage providing physicians' services in home, office, and institutional settings, providing coverage of at least the first $2,000 of medical expenses per person per year. The maximum deductible allowable would be $100 for a year (with credit given for expenses incurred in the last 3 months of the preceding year). Additional cost sharing is permitted, but the total of all cost sharing (deductibles, coinsurance, and copayments) cannot exceed 10 percent of the total expenses. (Thus, a person incurring $2,000 in expenses could pay a maximum of $200 for all cost sharing.)

5/ A nongroup policy, sometimes called an "individual policy," is a policy which covers one person or family rather than a policy including more than one (group policy).

A group health insurance policy could not exclude any preexisting conditions or require a waiting period before their coverage. A non-group contract could not exclude any preexisting conditions, except pregnancy, but could require a waiting period of up to 90 days after enrollment. Any policy providing coverage for a family must include all dependent unmarried children under age 22 and automatically cover any newborn (or adopted) children.

A health insurance policy covering an employment group must meet these following requirements:

(a) continue coverage for at least 31 days after termination of employment,

(b) offer terminated employees a reasonable opportunity to obtain a certified nongroup policy, and

(c) provide an annual open enrollment period to permit enrollment of employees who previously failed to elect coverage.

Allowage Exclusions

A certified health insurance policy may exclude payment for--

(1) services covered under workmen's compensation, Medicare, or the catastrophic proposal,

(2) services where there is no legal obligation to pay (e.g., VA services),

(3) routine physical examinations,

(4) cosmetic surgery,

(5) charges for outpatient psychiatric services exceeding $250 in a year, and

(6) charges by a hospital for interns and resident physicians' services to the extent they exceed actual cost.

A policy may also exclude payment for charges which are not "reasonably priced." While this is not further defined, the bill indicates a charge would always be considered reasonable if not higher than the allowable charge under Medicare or the proposed catastrophic program.

Benefit-Premium Ratios

With regard to certification, the Department would establish a reasonable ratio of the amount of benefits paid to the amount of premiums collected (similar to a retention ratio). In determining the ratio, consideration would be given to the profit or nonprofit nature of the carrier and the number of subscribers in a group. In evaluating the ratio for a particular carrier, consideration would be given to the average ratio for similar carriers offering certified policies.

For individual policies, the ratio would initially be based on the ratio established for the smallest groups, but could be modified.

The Department would periodically review the actual experience of carriers with certified policies in order to determine if the policy continues to meet the requirements for certification.

Group Practice Plans

The requirements described above would not apply specifically to comprehensive prepaid group practice plans, but special requirements would be developed that would be equivalent, on an actuarial and benefit basis, to the general requirements.

Antitrust Exemption for Pools

The bill would suspend the antitrust laws of the Federal Government, the States, and political subdivisions to permit insurers to enter into arrangements to establish insurance pools to offer certified health insurance to the public. (Various Federal and other laws now make certain pools illegal.) These pool arrangements must be approved in advance of operation by the Department of Health, Education, and Welfare.

Report

The Department would report to the Congress within 3 years after enactment of the bill on the availability of certified insurance, and the extent of coverage, in each State.

LONG-STANTON BILL

The "Catastrophic Illness Insurance Act" was introduced by Senator Russell B. Long of Louisiana as S. 1416 and Representative J. William of Ohio as H.R. 8380.

Its provisions are identical to Title XX (Catastrophic Health Insurance Program) included in the Catastrophic Health Insurance and Medical Assistance Reform Act, introduced by Senators Long and Ribicoff as S. 2513.

SCOTT-PERCY BILL

"The Health Rights Act of 1973" was introduced by Senators Hugh Scott of Pennsylvania and Charles Percy of Illinois as S. 2756.

General Concept and Approach

The bill would establish an insurance program in the general population including (1) an inpatient health care program providing catastrophic protection against the cost of hospital and other institutional services and (2) a voluntary supplementary medical insurance program offering a broad range of medical and outpatient services. The bill provides for review of utilization of services, development of training standards for health personnel, and incentives for the development of health maintenance organizations.

INPATIENT HEALTH CARE PROGRAM

The inpatient program would provide catastrophic protection against the cost of institutional services (hospital, nursing home, and home health), with the amount of the benefit payment based on family income and size and the amount of the institutions' charges. It would be financed by the payroll tax now levied for the Medicare hospital insurance program and appropriations from Federal general revenues. The program would be administered by the Department of Health, Education, and Welfare, in part through contracts with private or public intermediaries or health maintenance organizations.

Coverage of the Population

All residents of the United States would be covered, including aliens admitted as permanent residents or for employment. (Aliens employed by foreign governments or international organizations could be covered under special agreements.) However, persons would be required to enroll in the voluntary supplementary medical insurance program as a condition for receiving inpatient benefits.

Benefit Structure

The following chart shows the covered services and any limitations applicable to them:

Type of service	Limitations
General hospital.....	No limit.
Tuberculosis hospital.....	No limit.
Psychiatric hospital.....	Maximum of 60 days per year, with a lifetime limit of 180 days.
Skilled nursing facility.....	No limit.
Home health services.....	No limit; available only following a stay in hospital or skilled nursing facility.

Covered services rendered in qualified Christian Science sanatoria are specifically covered under the bill.

The program would pay the cost of these services after a specified payment (the deductible) made by the family. The amount of the deductible would be based on the combined annual income of all family members (including dependents). Income is defined to include both adjusted gross income (as determined under the income tax laws) and nontaxable income such as public assistance and social security payments. In this calculation, the total family income would be rounded to the nearest $1,000.

From total family income, "per person family income" is derived by dividing this income by the number of family members, according to the following method: a factor of 1.25 for a one-person family, 1.75 for a two-person family, and an additional 0.50 for each additional dependent. Then, the "family health cost ceiling" is calculated as 15 percent of the per-person family income, except where this income is $2,000 or less, in which case the applicable percentage is 10 percent.

The family which incurs covered expenses is obligated to pay an amount equal to one-half the family health cost ceiling, and 50 percent (coinsurance) of the costs between this amount and the amount of the ceiling. This deductible could be paid out-of-pocket by private health insurance or other sources. The inpatient program would pay all additional costs that year.

For example, if total annual family income for a family of four persons was $10,000, their per-person family income would be $10,000 divided by 2.75, or $3,636. The family health cost ceiling would be 15 percent of the per-person income, or $545. If the hospital bill was $500, the family would pay $386. (This would be calculated as one-half of the health cost ceiling of $545, or $272, plus 50 percent of the amount between $272 and the $500 bill, or an additional $114.)

For a hospital bill of $1,000, if only the formula was applied, it would require a patient deductible of $636, but of course the payment would always be limited to the health cost ceiling, in this case, $545.

Low-income families would of course quickly reach their health care ceiling. For example, a four-person family with $4,000 income which incurs a $500 hospital bill would pay the ceiling of $145. (The $4,000 income divided by the factor of 2.75 would give per-person income of $1,454 and the ceiling would be 10 percent of that amount, or $145.)

The following tabulation shows, for selected income levels and family sizes, the family health cost ceilings--that is, the maximum payment regardless of the amount of the institutions' charges:

Total family income	Family size			
	1	2	4	6
$1,000	$80	$57	$36	$27
$2,000	160	114	73	53
$4,000	480	342	145	107
$6,000	720	514	327	161
$10,000	1,200	857	545	400
$20,000	2,400	1,714	1,090	800

Financing

The payroll tax now levied for the Medicare's hospital insurance program would be allocated to finance the new program, and the present Medicare Hospital Insurance Trust Fund would be transferred to a new inpatient health care trust fund. The additional costs of the proposal would be financed from Federal general revenues and also deposited in the new trust fund.

SUPPLEMENTARY MEDICAL INSURANCE

The supplementary medical insurance proposal would establish a voluntary program providing a range of outpatient benefits, subject to a deductible varying by family income and size. Costs would be financed by family premium payments, graduated according to the family size and income (with no contribution by the lowest income group) and from Federal general revenues. The program would be administered together with the inpatient program.

Coverage of the Population

All persons eligible under the inpatient health care program would be eligible to voluntarily enroll for supplementary medical insurance. Enrollment would be available during a general enrollment period open for 10 months in the first year of the program, and 2 months in each year thereafter.

Benefits

The services covered by the program and any limitations on these services are shown in the following chart. In general, the benefits include all of those provided by the supplementary medical insurance part of the Medicare program, as well as additional services.

Type of service	Limitation
Personal services:	
Physicians	No limit.
Psychiatrists and psychologists	26 visits per year, with a lifetime maximum of 104 visits.
Dentists, routine services	For children under age 12.
Home health professionals	No limit.
Other health professionals	No limit.
Laboratory and X-ray	No limit.
Outpatient physical therapy services	No limit.
Physical checkups	By regulation.
Well-child care	For children under age 5; 2 visits per year.
Prenatal care	By regulation.
Other services and supplies:	
Medical supplies, appliances, and equipment	Specified items, no limit.
Ambulance services	By regulation.
Prescription drugs	Drugs necessary for treatment of long-term or chronic illness, from specified list of covered drugs (listed by generic name) established by regulation.

Benefits would be subject to common deductible (applicable to all services) ranging from $10 to $50 a person in a year. However, a separate deductible of $10 to $25 a person annually would apply to dental care. The amount of the deductible would be based on per-person family income, as described previously, and thus would vary according to family size and income. (The deductible would be $50 a person if per-person family income exceeds $2,000, $25 between $2,000 and $1,000, and $10 if $1,000 or less. The equivalent deductibles for dental care would be $25, $15, and $10, respectively.) The amount of the deductible, according to total family income and size, is indicated as follows:

Total family income	Medical				Dental			
	Family size				Family size			
	1	2	4	6	1	2	4	6
$1,000	$10	$10	$10	$10	$10	$10	$10	$10
$2,000	25	25	10	10	15	15	10	10
$4,000	50	50	25	25	25	25	15	15
$6,000	50	50	25	25	25	25	15	15
$10,000 and over	50	50	50	50	25	25	25	25

Financing

The proposal would be financed by premium payments by the covered families, with contributions from Federal general revenues for all or part of the premium cost for low-income families. The Federal contribution would again be based on the per-person family income. (The government would pay 100 percent of the premium if per-person family income is $1,000 or less, 75 percent between $1,001-$1,500, 50 percent between $1,501-$2,000 and 25 percent between $2,001-$2,500.) The results of applying this formula, according to total family income and size, are illustrated below.

Total family income	Percent of premium paid by government			
	Family size			
	1	2	4	6
$1,000	100	100	100	100
$2,000	50	75	100	100
$4,000	0	25	75	75
$6,000	0	0	25	50
$10,000	0	0	0	0

The family share of the premium would be paid directly to the intermediary assigned to the region (as described later). If the family fails to pay its premium on time, coverage could be continued, as prescribed by regulations, for a maximum of 1 year. Also, intermediaries could enter into agreements with employers to deduct premiums from employees' wages. Employers could of course pay all or part of the premiums, as agreed with employees, and the bill specifies that the new law could not further restrict any health benefit contract or agreement now in effect, or made in the future.

The Federal Government could deduct the premium from the cash benefits of beneficiaries of the social security, railroad retirement, and civil service retirement systems for beneficiaries electing coverage under the new program. These deductions as well as the government contribution for low-income people would also be paid to the intermediary.

A supplementary health care trust fund would be created to temporarily hold the government contributions and deductions, and the present Medicare Supplementary Medical Insurance Trust Fund would be transferred to this new fund.

PROVISIONS APPLICABLE TO BOTH PLANS

Administration

The program would be administered by the Department of Health, Education, and Welfare through a newly created office of health care. The director of this office would be appointed by the President with the advice and consent of the Senate. In administering the program, the Department could utilize the services, facilities, and records of other Federal agencies, and of State, local and private agencies, through contracts, agreements, or other means.

Determination of Eligibility

The Department would be responsible for determination of eligibility (family income, size, health cost ceilings, etc.) for both parts of the program. It could review eligibility at any time, if it believed family circumstances have changed, but not more than twice a year. Families must report any changes affecting eligibility whenever these changes occur.

Administration of Benefits

The Department would contract with insurance carriers or other public or private administrative intermediaries, or with health maintenance organizations, to administer the two programs. The intermediaries, which would need to meet standards established by the Department, would be assigned to specified geographical regions. They would receive and pay claims of providers of services and perform other assigned duties (such as the collection of premiums as described previously).

The bill guarantees patients freedom of choice in obtaining health care from any qualified provider willing to provide the services.

Provision is made for appeals and judicial review by individuals dissatisfied with determinations on entitlement for benefits, and for providers determined to be ineligible to participate in the program.

Relationship to Other Government Programs

The bill would repeal the Medicare law and the present health insurance programs for active and retired Federal employees. Federal grants for the Medicaid assistance program would be limited to services not provided under the proposal. By regulation, a new minimum scope of benefits would be required for State Medicaid programs (in lieu of present requirements), designed to supplement the benefits of the new program.

Standards for Providers of Service

Institutional facilities (hospitals, skilled nursing facilities, and home health agencies) would be required to meet certain minimum standards specified in the bill. (These standards are similar to those of the present Medicare program shown on page 225.)

As described later, the National Professional Review Council could review the staffing patterns of providers of service, and their standards for the selection and retention of professional and allied health personnel, and could order a revision of these staffing patterns or standards.

Professional and allied health personnel who meet the Council's national standards and are legally authorized to practice their profession in a State would be authorized to practice in any State, either independently or for an organization.

Reimbursement of Providers of Service

Reimbursement of providers of service would be based on the reasonable cost of services, according to the provision of the present Medicare law. The bill also provides special provisions for reimbursement of health maintenance organizations on a per capita basis, as described later.

Delivery and Resources

Health Maintenance Organizations

Under the bill, a health maintenance organization (HMO) would be a public or private organization which provides services, directly or through arrangements, to enrollees on a per capita prepayment basis. It would need to provide all the benefits insured under the proposal. The organization must demonstrate that it is financially responsible and capable of delivering health services effectively, efficiently, and economically. It must assure that services are received promptly and meet quality standards established in regulations.

As indicated above, the Department could enter into contracts with HMO's to provide the services insured under the proposal. Persons eligible under the insurance provisions of the proposal would be eligible to join the HMO's during open enrollment periods. By regulations, total membership in the organization may be limited, but an applicant could not be denied membership because of age or health conditions.

The total per capita payment to the organization under a contract could not be greater than the average cost for these insured services for other families in the region. As for intermediaries, the family premium payments and the Federal premium subsidies and withholdings would be paid to the organization.

The HMO itself could pay its professional staff (for example, physicians and dentists) as employees or partners of the HMO, or could make arrangements for services with professional groups and pay them on a per capita or fixed amount basis.

The bill authorizes, for the first 3 years of the program, Federal loans and grants of funds necessary for the cost of planning, establishing, and constructing HMO's as follows:

(1) Grants up to a maximum of 50 percent of the costs of developing an organization. In physicians shortage areas, up to 70 percent.

(2) As prescribed by regulation, loans at 3 percent interest, repayable over a 20-year period.

A provision of the bill applicable to medical care institutions generally, as well as health maintenance organizations, provides that an organization meeting the standards of the National Professional Review Council, which is ineligible to incorporate under State law for reasons deemed incompatible by the Department, would be incorporated by the Council.

Review of Utilization of Services

The proposal absorbs many of the provisions of the Medicare program and of the Professional Standards Review Organizations (PSRO), established by P.L. 92-603 (H.R. 1), concerning review of the utilization of services. As under Medicare, the proposal contains provisions for review of utilization in medical care institutions by a committee composed of members of the institutions' staff.

The proposal also incorporates the provisions of the PSRO law establishing review organizations in various geographical areas composed of professional practitioners in the types of health care under review. It also incorporates the laws' provisions for coordination of activities among agencies and organizations involved in utilization review.

National Professional Review Council

The bill not only incorporates and amends the provisions relating to the National Professional Review Council, established by P.L. 92-603, and assigns to the Council duties similar to those under the present PSRO law, but also additional functions relating to the administration of the proposed program (some of which have been described above).

Under the bill, the Council would consist of 11 members appointed by the President, with the consent of the Senate, qualified by training and experience to appraise activities under the proposed program. A majority of the Council would be physicians and the other members would be other types of health professional personnel. The members of the Council would be recommended by national organizations representing professionals, consumer groups, and other health care organizations. The Council would have the following duties:

(1) review the operations of the State and area PSRO's to determine their effectiveness, and assist in the development and distribution of information and data;

(2) review, and advise the Department, concerning the overall administration of the proposed program;

(3) compile a list of generic prescription drugs for use by providers under the insurance provisions of the program;

(4) develop national standards for training of professionals and allied health personnel, after consultation and hearings with appropriate national organizations; and

(5) at its discretion, require revision of a provider's staffing patterns and a provider's standards for selection and retention of professional and other personnel, if the provider fails to meet the standards established by the Council on these matters.

Health Delivery Committee

The bill establishes within the Department a health delivery committee consisting of nine experts in health care, appointed by the President with the advice and consent of the Senate. The committee would study the current need for medical personnel and facilities and the estimated need for the next 20 years. It would study the solutions to these needs, with particular emphasis on the effectiveness of the HMO's established under the proposal.

MEDICARE PROGRAM
STANDARDS FOR PROVIDERS OF SERVICES

In order to participate in the Medicare program, providers of services have to meet certain statutory requirements and other health and safety requirements established by the Department of Health, Education, and Welfare.

Hospitals

General hospitals must be licensed under State law, maintain clinical records for all patients, have by-laws for their medical staff, have every patient under the care of a physician, provide 24-hour nursing service, and have a utilization review plan in effect. They must also meet health and safety requirements regarding their physical environment and the operation of their facilities and services.1/

Hospitals accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association are deemed to meet all the conditions of participation (except utilization review) although the Department has authority to establish standards higher or more precise than those of these organizations.

Tuberculosis and psychiatric hospitals must meet the same requirements as general hospitals and must be accredited by the Joint Commission as well as meet special requirements for medical records and staffing.

Skilled Nursing Facilities

Skilled nursing facilities must be licensed under State law, must maintain clinical records for all patients, have established policies regarding patient care, have every patient under physician supervision, provide 24-hour nursing service, have established procedures for dispensing drugs, and have a utilization plan in effect. They must also have a transfer agreement with a hospital and meet health and safety requirements regarding their physical environment and the services they provide. They are specifically required to meet the provisions of the Life Safety Code of the National Fire Protection Association applicable

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1/ Nonparticipating hospitals may provide emergency services under Medicare and these hospitals must be licensed under State law and provide 24-hour nursing service.

to nursing homes which the Department holds to be appropriate. They must also cooperate in an effective program of independent medical evaluation and audit of their patients.

Home Health Agencies

Home health agencies must provide skilled nursing services and other therapeutic services, be licensed under State law, maintain clinical records for all patients, have established policies for their services, and meet additional health and safety requirements.

Providers of Outpatient Physical Therapy Services

These providers include participating hospitals, skilled nursing facilities, and home health agencies. Clinics, rehabilitation agencies, and public health agencies can also be providers of outpatient physical therapy services if they are licensed under State law, maintain clinical records for all patients, provide an adequate program of physical therapy services for outpatients, have established policies for their services, and meet additional health and safety requirements.

Independent Laboratories

Independent laboratories must be licensed under State law and meet health and safety requirements regarding the qualifications of their personnel, recordkeeping, and the operation of their equipment and facilities.

Physicians and Other Professionals

Physicians must be legally authorized to practice medicine or surgery by the State in which they provide their services. Chiropractors, dental surgeons, and podiatrists have to meet similar requirements with respect to their services.

Other Suppliers of Services

Suppliers of portable X-ray services must be licensed under State law, and must meet health and safety requirements relating to physician supervision, qualifications of personnel, and safety standards for their equipment. Suppliers of ambulance service have to meet safety requirements for their ambulances and have trained personnel.

All Institutional Providers

All institutional providers are required to have a written plan reflecting an operating budget and a capital expenditures budget for the next 3 accounting years.

Discrimination Prohibited

Participating hospitals, skilled nursing facilities, and home health agencies must comply with the requirements of Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on race, color, or national origin.

ANNUAL REPORTS AND SPECIAL RELEASES

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Medical Care Costs and Price Background Book: 96 pp.

Released December 1973. Presents in summary form comprehensive data on medical care costs and prices in the United States. Subjects range from the cost of private health insurance to public benefit payments: from doctor's and dentist's fees to who pays them.

Selected State Data MEDICARE Fiscal Years 1968-71: 58 pp.

Released December 1972. Summarizes basic Medicare information for each State, the District of Columbia, and Puerto Rico; data on enrollment, amounts reimbursed, the providers of services, as well as some utilization data for hospitals and extended care facilities.

Size and Shape of the Medical Care Dollar 1972: 36 pp. $.35

A two-color chart book which presents in graphic form the background facts relating to the medical care dollar--who pays; what and how much is bought; for whom it is spent; and how and why it has grown. Released August 1973.

Compendium of National Health Expenditures Data: 89 pp. $1.50

Tables comprise all available data on health expenditures from 1929 to 1971. Released December 1972. The data cover not only direct consumer outlays for medical care and the proportion paid by private health insurance but also includes health outlays by public programs and by other sources of payment such as private health insurance, direct payments, and philanthropy.

Personal Health Care Expenditures By State, Volume 1: 151 pp. $2.40

Designed to assist State government officials, State and local planning agencies, and health researchers involved in the coordinated planning, organization, and delivery of medical care services at the State and local level. State data are presented for each public program by source of funds and type of expenditure for two fiscal years to provide some measure of the impact of Medicare and Medicaid.

Social Security Programs in the United States: 133 pp. $1.20

Brings together information through July 1973 on the historical development and present status of all the major income-maintenance programs in the United States and on the health insurance and medical assistance programs under the Social Security Act.

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Current Social Security Research Reports

Number	*Publication*	*Price*
42	*Woman and Social Security: Law and Policy in Five Countries*, by Dalmer Hoskins and Lenore E. Bixby. 95 pp.	$0.75
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